JEFFERSON COUNTY HUMAN SERVICES DEPARTMENT

2008
ANNUAL REPORT

Serving residents of Jefferson County

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JEFFERSON COUNTY HUMAN SERVICES DEPARTMENT
Serving the Residents of Jefferson County
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Ph: 920-674-3105 Fax: 920-674-6113

May, 2009

Dear Ms. Schmeling, County Board Chair
Members of the Jefferson County Board,
Members of the Jefferson County Human Services Board,
Mr. Petre, County Administrator
Other Interested Parties,

I am pleased to present you with the Jefferson County Human Services Department Annual Report for 2008. As in past years, this report has a good deal of detail about the major areas of Human Services programs and functions.

The programs and services of the Human Services Department continue to focus on assisting our consumers to live successfully in their own communities. Many of the individuals and families we serve present a disability or serious set of personal problems. Some are vulnerable and require protection from the circumstances they are currently living in. Others lack the personal skills necessary to sustain employment or personal relationships. And, some must struggle with permanent conditions such as chronic mental illness or developmental disabilities. We also recognize that everyone has strengths or personal assets that can be used or developed. Our staff assists county residents in developing these as a part of our overall set of services.

The past year was one of the most significant in the history of our Department in terms of major program, funding, and organizational changes. These included implementation of the Family Care and Partnership Programs, which transferred long term care management and financing responsibilities from Jefferson County Human Services to Care Wisconsin, a privately operated Care Management Organization, designing and opening the Jefferson County Aging and Disability Resource Center, a one stop resource center and gateway to Family Care for the elderly and other adults with developmental or physical disabilities, and completing a re-organization of the Department's management structure. All of the above included the creation of many new job descriptions, integrating service areas, contracting our Long Term Support social work staff to Care Wisconsin, and significant changes to our overall budget, which in 2009 is reduced nearly 50% from 2008 due to the transfer of long term care funding to Care Wisconsin via a State contract. Also complete were continuing improvements in our Behavioral Health Services, including certification as a Medicaid Funded Emergency Services provider. This certification provides an improved mental health crisis response system for persons in need, while reducing county tax levy costs for emergency hospitalizations.

An overriding concern over the past year, which carries into 2009 and likely 2010, is the poor national, state and local economy. Job losses, layoffs, and a general poor business climate have driven many more citizens into poverty or near poverty situations. Readers should note the continuously rising numbers of Jefferson County residents receiving public assistance programs including Badger Care, Food Assistance Program and consequent increases in all Workforce Development Center services. Interested persons should review the Jefferson County Workforce Development Center Annual Report as well. Many county residents have used our

services for the first time and many more, particularly those with mental health, family, chemical dependency, or poverty issues have needed even more assistance and support to maintain themselves and their families.

On a personal note, this is the twenty first and final Annual Report for me as Human Services Director for Jefferson County as I will retire on May 8 of this year. It has been my privilege to have been part of the development and continued implementation of Human Services in Jefferson County for nearly thirty two years. We have a Department that we can be proud of that has consistently been in the forefront of Human Services development and evolution, providing services and meeting our public obligations in a fiscally prudent manner. The Human Services staff deserve on-going recognition for their talent, commitment to Jefferson County and so much tireless work for so many. No one could have asked for a finer group to work with. I also want to recognize our current Human Services Board, especially our leader Jim Mode, for equally tireless work and commitment to our consumers and to County Government. Thanks to all the other Department Heads for years of partnership and a huge thanks to the community of Jefferson County. It's been a great place to belong to.

Warmest Regards,

Thomas Schleitwiler, Director
Jefferson County Human Services (1977-2009)

MISSION STATEMENT

Enhance the quality of life for individuals and families living in Jefferson County
by addressing their needs in a respectful manner,
and enable citizens receiving services to function as independently as possible,
while acknowledging their cultural differences.

VISION STATEMENT

All citizens have the opportunity to access effective and comprehensive
human services in an integrated and efficient manner.

HUMAN SERVICES BOARD OF DIRECTORS

2008 – 2009

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John McKenzie

Martin Powers

James Schultz

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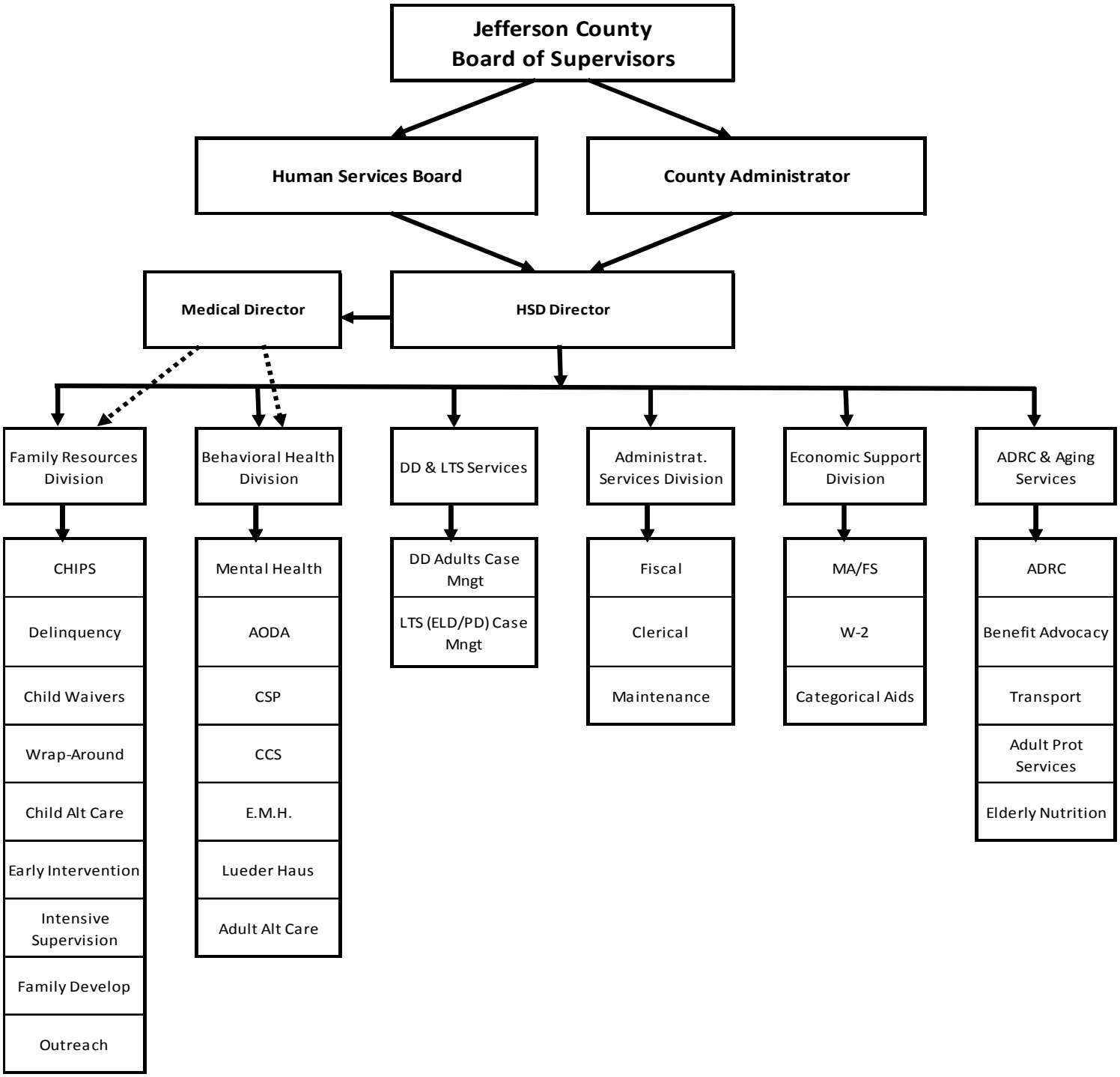
Marion Moran
Mike Mullenax
Lori Partoll
Earlene Ronk
Yvonne Stueber
Sue Torum, Staff
Karen Tyne, Staff

Organizational Chart



RESOURCE ASSISTANCE

~ Our goal is to provide accurate, timely, supportive and effective services for our customers.~

Access and Resources are the main focus of the staff in the Resource Assistance Unit. Our goal is to provide accurate, timely, supportive and effective services for our customers.

The Resource Assistance Programs of Jefferson County are administrated through the staff at the Workforce Development Center.

The location of financial assistance programs at the Workforce Development Center provides staff with the ability to readily connect the customer to other Federal, State and community programs. This One-Stop Operation of Services reduces the customer's need to travel between agencies and coordinates the services of the on-site providers: Job Services, the Department of Vocational Rehabilitation, Opportunities, Inc., WIA Adult and Youth Programs, and Jefferson County Economic Development Consortium. Community Partners also serve an important role in service coordination. Some of these partners include Community Action Coalition, Madison Area Technical College, Local School Districts, the Faith Based Organizations and Local Employers. Employment services are provided regionally to facilitate coordination of customers who live in one county and are employed in another.

If you are interested in learning more about the agencies and services available to meet your workforce needs, you can visit the Workforce Development Center's website at http://www.comeherefirst.org or the new site at JobCenterOfWisconsin.com.

Presently, our Resource Assistance programs are serving over 4,701 Jefferson County households per month. Customers may be receiving assistance from Medicaid, BadgerCare Plus, FoodShare, Wisconsin Shares, Wisconsin Works, and/or Kinship. Further, our customers may also receive financial assistance from St. Vincent de Paul or Energy Assistance.

Following is a brief description of each program and the number of customers receiving these benefits in 2008.

Wisconsin Works W-2

The Wisconsin Works program began in 1997 and made significant changes to the financial assistance received by Wisconsin families. Jefferson County has successfully received the grant funding for the W-2 program since its inception and presently maintains the contract. The W-2 program focuses upon alleviating the specific employment barriers a family member may have.

By providing intensive case management and service coordination, the program works to determine how a customer's strengths can be enhanced, employment obtained and maintained with an emphasis on stabilizing household income to guide the family to self-sufficiency.

The Financial Employment Planners (FEP) serve as the first point of contact for all customers contacting our agency for financial and support services. The FEP is responsible to assess the customer's needs, initiate the application process and coordinate the appropriate referrals to community resources and financial support programs.

Some customers may have more complex circumstances that require the FEP to develop an individual employability plan that isolates the household's employment barriers. These barriers could be transportation, education, training, physical or mental disabilities, or the care of a child under the age of 12 weeks.

The FEP addresses these issues through either the W-2 Employment Program or the voluntary FoodShare Employment and Training Program (FSET). The FEP will use a variety of tools, including work experience, employment workshops, career development, one to one counseling and also coordinate services for housing, literacy and energy assistance. Through this intensive case management, the goal is for the customer to successfully return to the workforce with the supportive programs of Badgercare Plus and FoodShare providing the continued stabilization needed.

Customers enrolled in the W-2 Program are required to participate in developed activities for 40 hours per week. After complete participation, the customer will receive a monthly payment of $628.00 or $673.00 per month depending upon their employment placement. Those customers volunteering for the FSET program work closely with the FEP to determine their participation hours based upon their individual needs.

The number of participants in the W-2 program remains low since the up front and case management services are comprehensive and the customer's needs may be able to be met through other financial assistance programs in lieu of W-2. In 2008, the W-2 case management only program ended as a separate category as all W-2 payment customers receive case management.

Also in 2008, the W-2 Program moved from the Department Of Workforce Development into the new Department of Children and Families, whose focus is on promoting the safe, economic and social well being of children and families. The website for the Department of Children and Families is http://www.dcf.wisconsin.gov.

Participants Receiving	2006	2007	2008
Payments	51	47	54
Case Management	3	3	Program Ended

Economic Support Programs

The Economic Support Programs serve to provide greater financial stability for low income households and those experiencing a financial loss. Each program serves a specific population and has different income guidelines and requirements. The self-sufficiency of Jefferson County households and individuals is the ultimate program goal. The number of customers requesting financial assistance from Economic Support Programs continues to grow each year with the greatest increase occurring from 2007 to 2008.

The Economic Support programs continue to become more and more important due to recent lay offs and the current economic concerns.

Caseload Growth

2005 3,969 households receiving benefits
2006 4,068 households receiving benefits
2007 4,201 households receiving benefits
2008 4,710 households receiving benefits

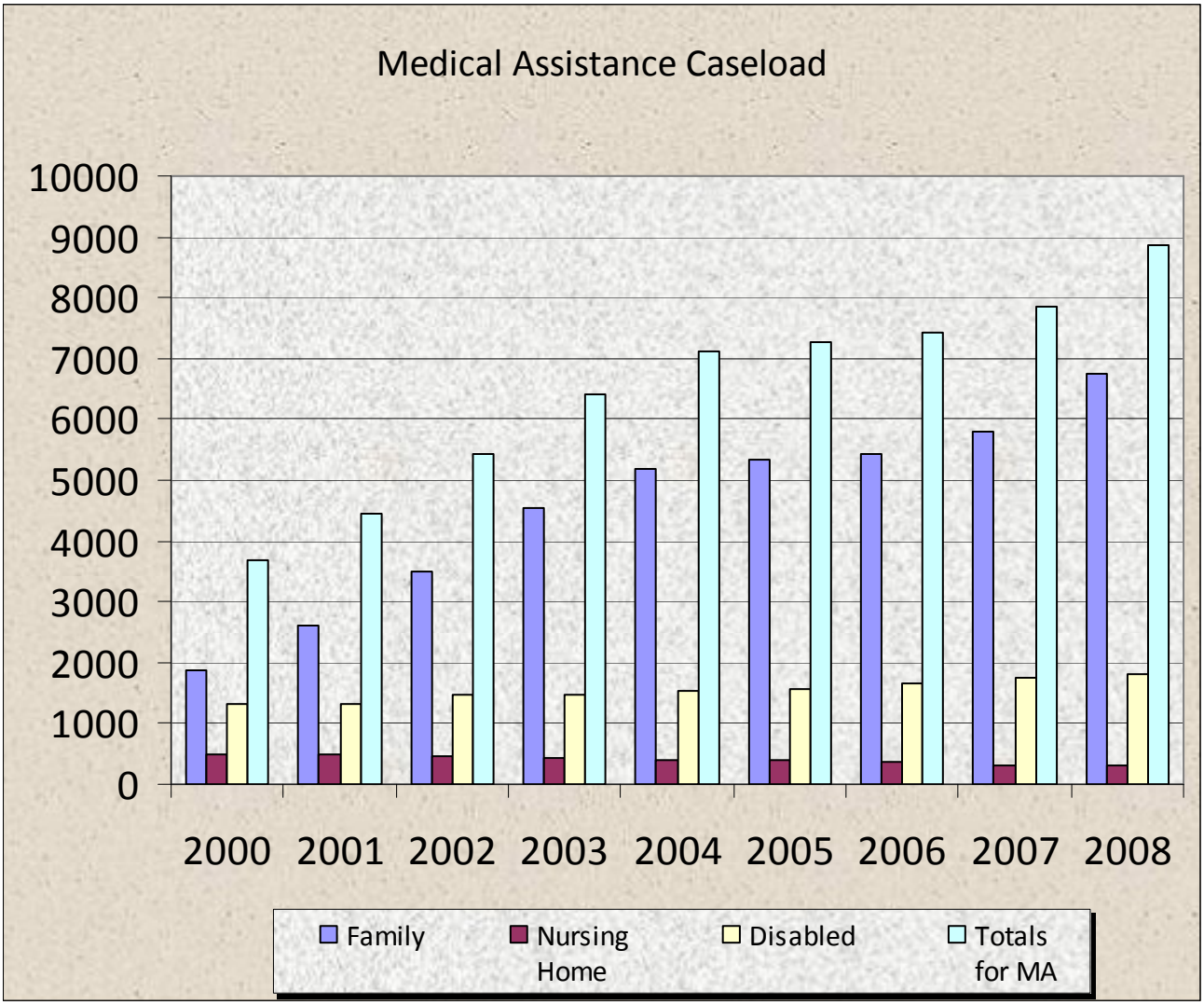
Requests for program assistance are made by contracting the Workforce Development Center at 920-674-7500 and asking to speak for an intake worker or you may complete an on line application at www. access.wisconsin.gov and the application will be directed to our office.

MEDICAL ASSISTANCE- is a State and Federally funded program that provides the low income customer comprehensive, affordable healthcare. Medical Assistance is also known as MA, Medicaid and Title 19. Numerous individual programs are included in the umbrella of Medical Assistance, some are, Badgercare Plus, Medicaid Purchase Plan, Family Planning Waiver, Medicare Beneficiary and Family Care. Medical Assistance encompasses eligibility for children up to age 19, disabled individuals, pregnant individuals, families with children under 19 in their home and the elderly over age 65. The eligible customer receives a white Forward card which is taken the Health Care provider to verify coverage. Most Medical Assistance customers must participate in an HMO. In 2008, the Family Care Program began providing case management services to the elderly and disabled. In 2009, BadgerCare Plus for Childless Adults will be implemented for those single individuals in need of health care. The Medicaid website is http://dhs.wisconsin.gov from which you can access information on individual program benefits and requirements.

The following chart shows a continuous increase in the number of customers receiving Medical Assistance in Jefferson County. In 2007, we provided Medical Assistance coverage to 7,880 customers. In 2008, the number of customers eligible for benefits increased to 8,865. It is expected these participation numbers will continue to increase as health care expenses rise, and the economic downturn is reflected in more individuals losing their employment.

Medical Assistance Participation

Caseload on December 30				
	Family	Nursing Home	Disabled	Totals for MA
2000	1864	505	1314	3683
2001	2607	505	1321	4433
2002	3500	473	1462	5435
2003	4526	415	1481	6422
2004	5190	406	1522	7118
2005	5345	384	1551	7280
2006	5418	357	1661	7436
2007	5802	321	1745	7868
2008	6753	315	1797	8865



FOODSHARE-Food Stamps is a Federal Program that provides a monthly Foodshare allotment to low income customers. Eligibility is based upon income, household composition and shelter expenses. The eligible customer receives a QUEST card that is used to purchase food at grocery stores. Customers in search of employment may volunteer to participate in the FSET program and work in coordination with a FEP to develop their employability resources. Like the Medical Assistance Programs, Foodshare participation continues to increase. The Foodshare caseload in 2007 was 1,423 households with a total average benefit issuance of $244,440 per month to be used in our communities. In December 2008, the caseload was 1,832 households with a benefit issuance of $373,606. The chart below shows the increase in the number of Foodshare customers from 2005 to 2008 in Jefferson County. The Foodshare website is http://dhs.wisconsin.gov/foodshare.

FOODSHARE

Year	All Recipients	Adults	Children	Groups
2005	4,498	2,233	2,265	1,850
2006	5,118	2,519	2,623	2,055
2007	5,672	2,765	2.907	2,320
2008	6,376	3,209	3,204	2,610

WISCONSIN SHARES-CHILD CARE - is a program that provides child care subsidies for low income working families to assist in their payment of child care expenses. The subsidy payment is made to the child care provider, with the family responsible for the co-payment. In December 2008, the monthly state average amount paid by a customer was $87.97 with the childcare program paying $575.81. In 2008, the average monthly number of Jefferson County families receiving child care assistance was 252 households. Statewide statistics indicate that 89.21% of the families receiving child care assistance have only one parent living in the household. Additionally, the Child Care case managers certify in home child care providers, participate in local children's fairs, and present trainings for providers. The child care website is http://dcf.wisconsin.gov/childcare/wishares

KINSHIP- is a program that provides monthly payments for non-legally responsible relatives caring for a child. The child may be unable to live with their parents due to incarceration, medical concerns or parenting issues. The relative receives the payment to help with the additional expenses incurred. In 2007, 25 children per month were served, with 15 children on the wait list due to limited funding. In 2008, 22 children per month received payments with 23 children on the waiting list.

JEFFERSON ST. VINCENT DE PAUL SOCIETY- continues to provide our agency access to local funds for the School District of Jefferson's customer's emergency needs such as rent and utilities, unmet by other programs. In 2007, St. Vincent de Paul provided $14,982.00 for 233 customers. In 2008, 186 customers received $21.984.51 in emergency funding.

EMERGENCY ASSISTANCE- is a program designed to meet the immediate needs of an eligible family facing a current emergency of fire, flood, homelessness or impending homelessness. In 2007, 72 households received $33,803.48 in grants, with an average grant of $469.49. These households included 92 adults and 149 children. In 2008, 89 households received $41,230.42 with an average grant of $463.26 each. These households included 110 adults and 181 children.

HOUSING - our division includes a housing coordinator whose focus is to assist impending homeless and homeless families and individuals with locating, securing and maintaining safe, affordable and accessible housing. In, 2007, services were provided to 87 households consisting of 113 adults and 120 children. In 2008, 100 households received these services consisting of 125 adults and 128 children. Our housing efforts continue to be coordinated with the Community Action Coalition and other local housing providers.

ENERGY ASSISTANCE- is a program that provides a one time payment during the heating season to customers below 150% poverty who need help paying their heating costs. The energy payment is made directly to the fuel supplier. Jefferson County continues to contract with Energy Services to administer the program. In 2007, 1,293 households received $391,731 in payments. In addition, crisis assistance funds may be provided to those in emergency situations. In 2007, 500 crisis payments were issued in the amount of $146,223. In 2008, 1,479 households received $510.137 in energy payments with additional crisis funding going to 1,177 households in the amount of $290,102. Program information can be found at http://heat.doa.state.wi.us

The Resource Assistance Programs continue to be modified and enhanced to meet our customer's changing needs. The ACCESS website (www.access.wisconsin.gov) allows the customers to complete a quick test for potential eligibility, apply for benefits on-line, report changes to their case manager and check their benefits.

This initial screening determines potential eligibility for numerous financial resources including Foodshare, BadgerCare Plus, Medicaid, SeniorCare, Medicare Part D, WIC, Energy Assistance and Earned Income Tax Credits. The customer is able to submit their application electronically to the agency and then provide the verifications needed at a later date. Currently, we receive an average of 75 ACCESS applications per month.

In 2008, staff completed the scanning of the entire caseload into the State Electronic Case Filing System. By June of 2008, all of the more than 4,700 case files had been scanned. With each case file having many required forms and verifications this has been an enormous accomplishment for the staff. The Electronic Case File system provides another service to our customers as the documentation provided to one agency is readily accessible to another, preventing any interruptions in benefits if the customer moves between counties.

As we move into 2009, the downturn and uncertainty of the economy continues to provide ongoing challenges for Resource Assistance. The increasing unemployment rate and the loss of health insurance have brought many new customers into the Workforce Development Center to access programs of financial assistance and re-employment services. These customers are often unfamiliar with the specific requirements that must be met for eligibility and may be frustrated with the process.

Our challenges become how to serve an ever increasing number of customers with quality customer service and how to continually find the time the customers deserve to have someone listen to their concerns. Additionally, we must continue to process all the resource assistance benefits timely and accurately. Yet, these challenges can be met. The coordination of programs and community partners, new technology for easier program access, and the caring and knowledge of the Resource Assistance staff all provide the avenues necessary to meet these challenges.

PERSONAL ASSISTANCE PROGRAMS

~ A Departmental value is keeping families together whenever possible and assisting them to live in their own communities. ~

The Personal Assistance Programs provide protection and rehabilitation services to individuals who are vulnerable, such as abused children; have high needs such as the mentally ill or developmentally disabled; poor or uninsured; and court-ordered individuals such as intoxicated drivers and delinquent youth.

For the past several years the average number of County residents served in Personal Assistance programs has risen at least slightly most years. During 2008 overall numbers have decreased somewhat. Most of this decrease is due to the county's participation in Family Care, which is discussed more fully in later sections of this report. Under Family Care consumers who are elderly, developmentally or physically disabled are now served by Care Wisconsin under a contract with the State. As of February of 2009 all consumers in the above categories have been transferred to Care Wisconsin. Interested readers should review the Aging and Disability Resource Center, and Developmental Disabilities sections of this report for more information.

Examples of Personal Assistance services include:

- Counseling, advocacy, and care management
- Community based living arrangements
- Assistance in Obtaining Public and Private Benefits
- Psychiatric care
- Elderly Services/Long Term Care
- Court Services for Child Protection and Youth Delinquency
- Adult Protective Services
- Infant Development Program

County residents are eligible for such services based primarily on criteria set by the Wisconsin Legislature and the Department of Health and Family Services. Federal, State, County and insurance funding determines the level of services provided to Jefferson County's citizens. The Department also provides some services that are not specifically mandated but provide prevention and support for individuals and families. When funding is inadequate, waiting lists for certain services are used if it is permissible. This is currently the case for funding for elderly, physically and develop-mentally disabled and brain injured persons. Persons with their own funds or private insurance are referred to private service providers when at all practical.

Generally speaking, families and individuals continue to present significant and very difficult problems. As social family stressors have increased, such as loss of insurance or financial benefits, family breakup, alcohol/drug influences, domestic violence, school failure, families, increased numbers of persons with physical or developmental disabilities, and an aging population, those without adequate support and resources have suffered the most. Unemployment has risen and remains a concern, as well as high numbers of working poor as evidenced by large increases in use of Income Maintenance programs such as Food Stamps and Badger Care. Many families and individuals that are seen in our Department continue to have multiple problems often involving the care and control of children, court involvement and serious school performance problems. It is necessary to spend a good deal of time with families when these problems are present. The numbers children and adults with very serious mental health problems has become a major concern. Readers will note the large numbers emergency mental health and suicide interventions, which the Department responded to during 2008. A specific report on this area is provided in the Mental Health section. Finally, as noted in last year's report we continue to see increasing numbers of Latino families entering the service system in all areas. Addressing the needs for these families requires a level of cultural understanding as well as practical needs such as translation and interpretation that the Department is working to achieve.

The Department's Medical Director/Psychiatrist provides medical/psychiatric services, while other professional staff provide individual or group counseling, education or other community services such as coordinating with schools, hospitals, police, nursing homes and the Courts. Intake staff respond to all service requests including emergency issues and child protection calls. Other valued services are provided to individuals or families in the home or within the community setting by *Community Outreach Workers* and *Family Development Workers*. The Department's

goal is to keep families together whenever possible and to have them stay in their own communities.

Providing excellent service requires a number of fundamental tasks. Social workers must become very familiar with the consumers they serve and trust must be established in order to determine and define the problems that will be worked on. The social work staff needs to be expert problem assessors. They need to be able to discuss all kinds of problems with their consumers and assist them to develop the means to change behaviors and habits which are harmful. In some cases, such as mental illness, developmental disabilities and frail elderly, people need assistance in dealing with permanent life situations before moving on to improve or recover as much as possible. Services such as psychiatric intervention and supportive alternate care placements often can improve their lives dramatically.

Our Personal Assistance Service Areas Include:

- Aging and Disability Resource Center
- Child and Family Services
  - Alternate Care
- Developmental Disabilities
- Early Intervention Program
- Mental Health and Substance Abuse Programs

REQUESTS FOR SERVICES AND CHILD PROTECTION

~ A program manager and team of social workers are specifically trained to assist families to improve their lives while protecting children.~

REQUESTS FOR SERVICES or assistance begin in the Intake area of our Department and are recorded as Contact Records.

The chart and graph on the following pages detail the contact records or requests for service, action or information that the Department received during 2007 and 2008. During 2008, the Department received a significantly larger number of service Intakes, (4,676) than in 2007, (4,164), and 2006, (3438). In response to the ever increasing number of requests for mental health services the Department became certified as an Emergency Mental Health Provider. Readers will note the large number of Emergency Mental Health (994) and Suicide (323) interventions during 2008. It is significant to note that most of these requests continue come to us from consumers who have no insurance or ability to pay for services. Readers should also note that this data continues to correlate to the increasingly large number of consumers in Jefferson County receiving Medical Assistance. As readers will note in the section on Economic Support Programs the numbers of persons on Medical Assistance has risen to 8865 during 2008, an increase of over 1000 persons when comparing 2007 and 1400 when compared to 2006. These are the highest numbers of Jefferson County residents receiving Medical Assistance programs on record.

Since CHILD ABUSE is a major concern and precursor to many other life problems, special attention is given to this area. Child abuse reports

are received from members of the public including neighbors, relatives and friends of families where abuse or neglect is a concern or potential concern. A large number of reports are also received from schools, police departments, physicians and other service providers or professionals. Each report is handled according to our legal requirements for child abuse investigation and child protection. The procedures involved with child protection investigations have become more comprehensive and time consuming over the past several years.

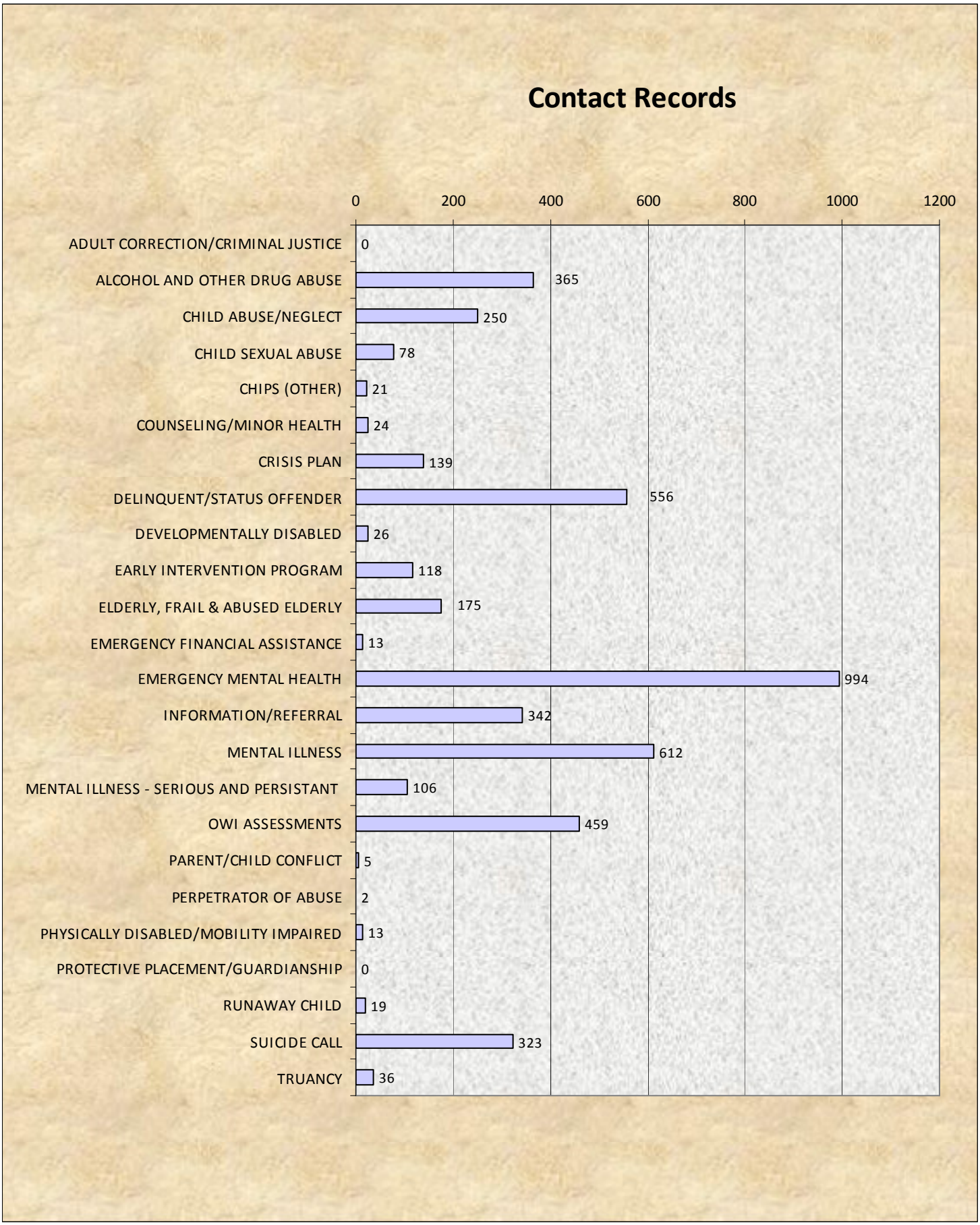
Child abuse records in Wisconsin are registered and tracked in a computer based system known as WISACWIS, (Wisconsin Automated Child Welfare Information System). This system provides a very detailed computerized system for documenting and reporting child welfare referrals and providing on-going services, including out of home placements. The child welfare reports, which generate local reports, are automatically sent to a central statewide data base. The overall hope in establishing this system in Wisconsin is to improve child protection and family service programs and to provide a consistent level of family-centered services statewide known as the "Wisconsin Model." In addition to this a recently completed Federal Audit of Wisconsin's Child Welfare System has prompted another set of training, practice and recording requirements for Wisconsin Counties. Consequently, more time is required on a per case basis to perform the necessary work and to produce documentation of the results both at both Intake and Ongoing Work stages. This difficult and time consuming work requires our workers to constantly make judgments that deeply affect the lives of children and their families. These decisions can include removing children from their homes in cases of severe danger, and requesting intervention of the Court. Other cases can involve no action on our part at all. Both types of decisions carry potential benefits and consequences for families and for the Department.

The Department continues to provide a comprehensive child/family treatment program for child abuse/neglect as well as other related family problems. A program manager and team of social workers are specifically trained to assist families to improve their lives while protecting children. Additionally, many county-wide collaborative efforts are aimed at improving overall services for families by implementing best practice models. These include the work of; the Jefferson County Delinquency Prevention Council, the Jefferson County Wraparound Project, Dialog for Student Success of Watertown, and the Jefferson County Family Impact Seminars.

PERSONAL ASSISTANCE
CONTACT RECORDS

DESCRIPTION	2008 INCIDENTS	2007 INCIDENTS	YEAR 2008 INCREASE/DECREASE
ADULT CORRECTION/CRIMINAL JUSTICE	0	6	(6)
ALCOHOL AND OTHER DRUG ABUSE	365	330	35
CHILD ABUSE/NEGLECT	250	266	(16)
CHILD SEXUAL ABUSE	78	93	(15)
CHIPS (OTHER)	21	10	11
COUNSELING/MINOR HEALTH	24	43	(19)
CRISIS PLAN	139		139
DELINQUENT/STATUS OFFENDER	556	583	(27)
DEVELOPMENTALLY DISABLED	26	45	(19)
EARLY INTERVENTION PROGRAM	118	112	6
ELDERLY, FRAIL & ABUSED ELDERLY	175	129	46
EMERGENCY FINANCIAL ASSISTANCE	13	8	5
EMERGENCY MENTAL HEALTH	994		994
INFORMATION/REFERRAL	342	402	(60)
MENTAL ILLNESS	612	563	49
MENTAL ILLNESS - SERIOUS AND PERSISTANT	106	122	(16)
OWI ASSESSMENTS	459	454	5
PARENT/CHILD CONFLICT	5	21	(16)
PERPETRATOR OF ABUSE	2	0	2
PHYSICALLY DISABLED/MOBILITY IMPAIRED	13	6	7
PROTECTIVE PLACEMENT/GUARDIANSHIP	0	10	(10)
RUNAWAY CHILD	19	46	(27)
SUICIDE CALL	323	253	70
TRUANCY	36	21	15
TOTALS	4676	3523	**1153**

CRISIS PLAN AND EMERGENCY MENTAL HEALTH ARE NEW CATEGORIES OF CONTACTS IN 2008


Contact Records
0
200
400
600
800
1000
1200
ADULT CORRECTION/CRIMINAL JUSTICE
0
ALCOHOL AND OTHER DRUG ABUSE
365
CHILD ABUSE/NEGLECT
250
CHILD SEXUAL ABUSE
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0
RUNAWAY CHILD
19
SUICIDE CALL
323
TRUANCY
36

During 2008, 245 investigations were done involving 329 children which is an increase from 2007 which involved 263 children.

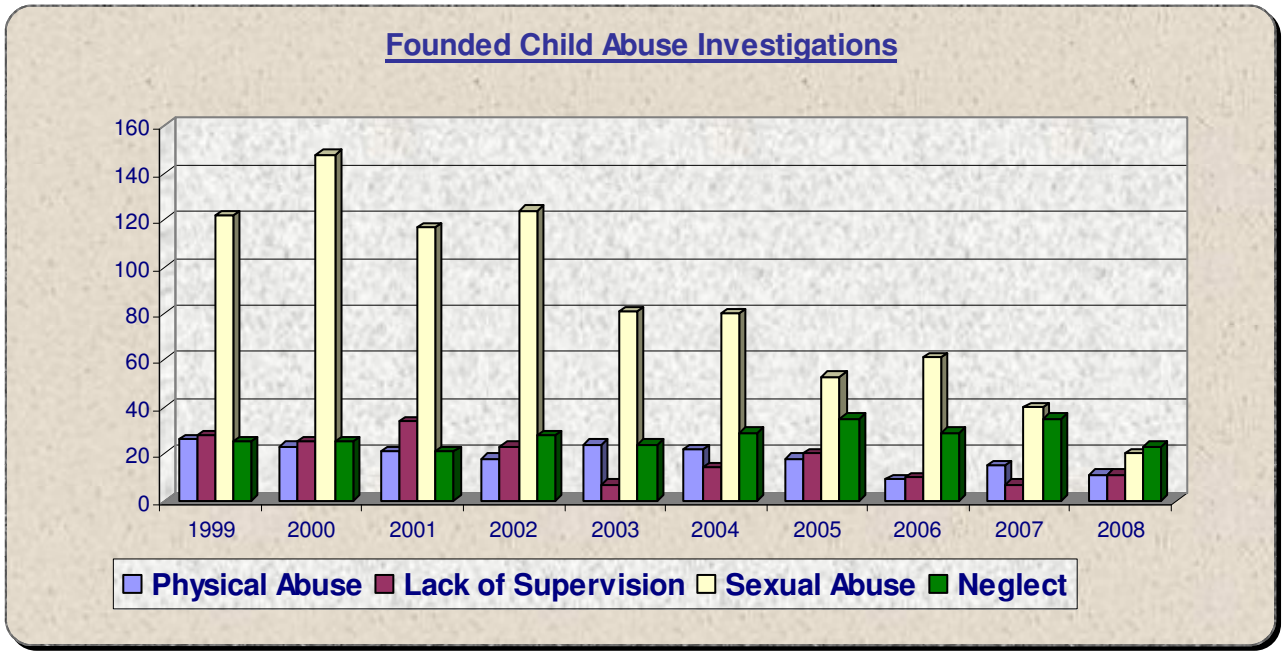
CHILD ABUSE/ NEGLECT REPORTS - 2008

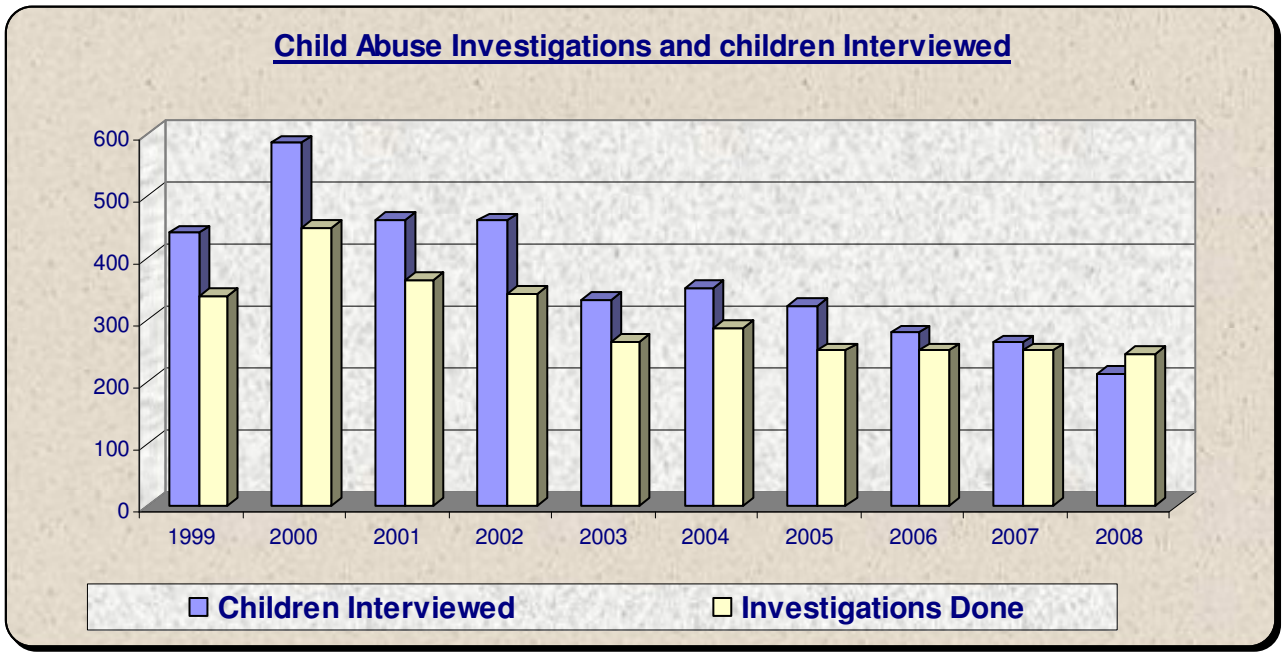
Types of Maltreatment	Founded	Unfounded	Not Able To Substantiate	Total Children Interviewed
Physical Abuse	11	44	3	**58**
Sexual Abuse	20	38	2	**60**
Neglect	23	47	0	**70**
Lack of Supervision	11	13	0	**24**
Totals	**65**	**142**	**5**	**212**

149 Investigations

There were an additional 96 referrals regarding 117 children that were screened out after the initial intervie

Readers will note from the following graph, which tracks a ten year record that the overall numbers of reports and founded cases has continued to decline. Particularly significant is the reduction in founded sexual abuse cases which have declined from over 140 in 2000 to 20 in 2008. This is certainly a hopeful indicator that would indicate that prevention and community awareness of this serious concern is having a positive impact. Additionally it should be noted that two changes have taken place that affect the total founded cases of sexual abuse. Non-care giver or stranger abuse is no longer automatically reported as child abuse, nor is consensual sexual behavior among teen agers. Stranger abuse is handled by law enforcement as a criminal matter and sexual consensual sexual behavior is dealt with by families using private or public counseling or intervention resources. We continue to provide assistance to law enforcement and to families when requested in these situations. Over the same time period other forms of abuse including neglect and physical abuse have remained at fairly similar numbers over the years.

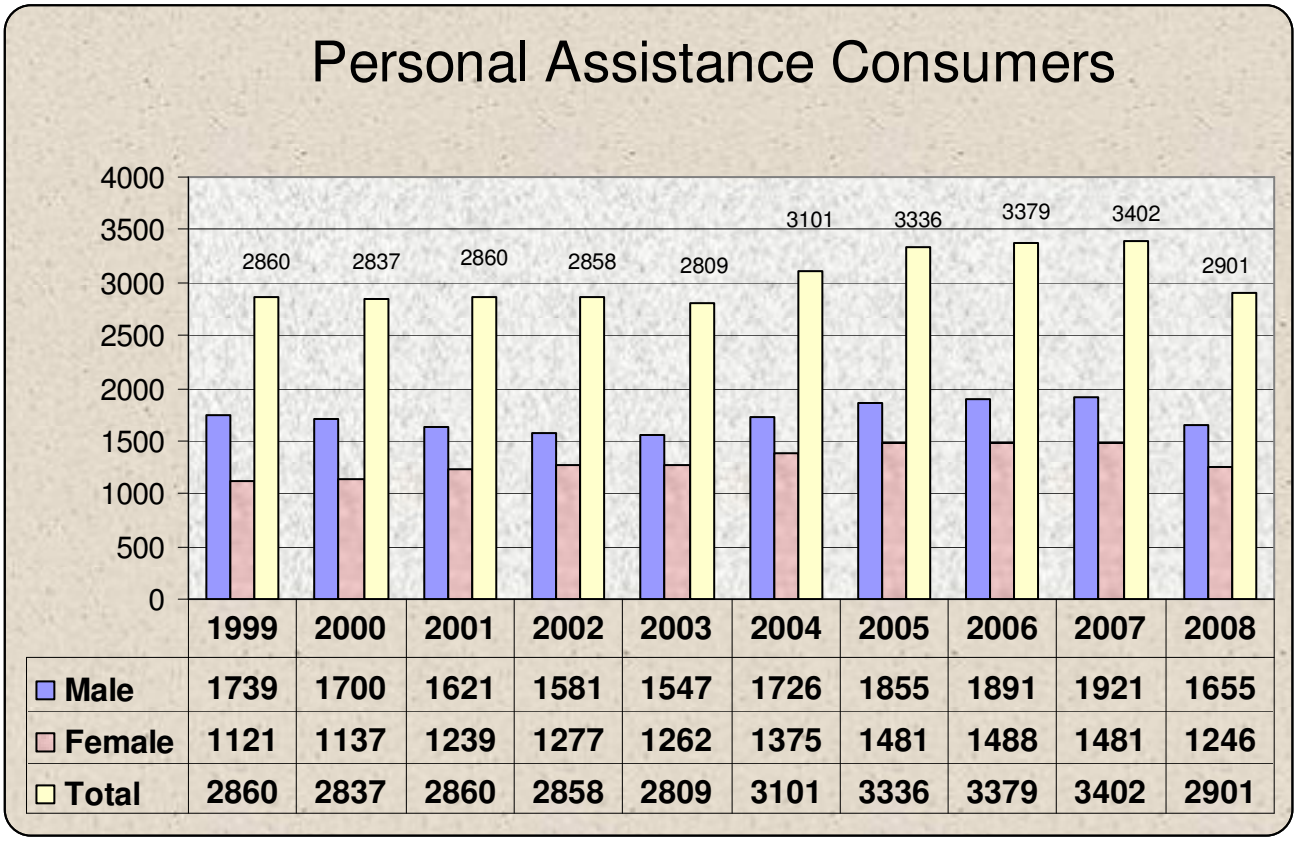




As noted earlier, the prevention and treatment for child abuse or neglect requires a community-wide approach. We are fortunate that Jefferson County is highly collaborative and county-wide partners have worked together for years in implementing best practice programs and services. Of particular note has been our work in providing Family Impact Seminars, which provide community education and promote best practice methods for supporting the family and our Jefferson County Delinquency Prevention Council, which has not only promoted best practices for dealing with delinquency, but has promoted programs which protect children and strengthen families. Examples include bringing Big Brothers/Big Sisters to Jefferson County, establishing an anti-bullying program for area

schools, and supporting county-wide dissemination of child development and parenting information. And finally, the On-Going Child Protection and Services Team, (CHIPS Team), at Human Services provides a wide range of family treatment programs and services designed to improve parenting skills, family relationships and connections to community organizations and people who can provide additional assistance. The Jefferson County Wraparound Project which is discussed later, is also an important resource for our CHIPS Team and the families they serve.

The following tables and graph represent the breakdown of our Personal Assistance customers according to caseload, gender and age for the past three years. A total of 2901 different people received some services during the year. Readers will note that the largest categories of service are Developmental Disabilities, Mental Health, and Youth Delinquency. Additional information on each of these areas follows.



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Male	1739	1700	1621	1581	1547	1726	1855	1891	1921	1655
Female	1121	1137	1239	1277	1262	1375	1481	1488	1481	1246
Total	2860	2837	2860	2858	2809	3101	3336	3379	3402	2901

PERSONAL ASSISTANCE CONSUMERS BY AGE				
Age	Female	Male	Total 2008	Percent
Under 6	121	178	299	10%
6-13	78	105	183	6%
14-17	80	176	256	9%
18-24	136	207	343	12%
25-35	200	288	488	17%
36-59	419	528	947	33%
60+	212	173	385	13%
TOTAL	**1246**	**1655**	**2901**	**100%**

CASELOAD DATA

AVERAGE CONSUMERS SERVED PER MONTH

2006-2008

CHARACTERISTIC GROUPS	2006	2007	2008	Ratio 2008	Average Change 2006-2008
MENTALLY ILL	281	297	306	23.01%	**17**
ALCOHOL & DRUG	46	66	69	5.19%	**13**
INTOXICATED DRIVER	90	93	88	6.62%	**(3)**
DEVELOPMENTALLY DISABLED	345	395	362	27.22%	**(8)**
PHYSICALLY DISABLED	52	61	44	3.31%	**(12)**
ELDERLY	112	125	82	6.17%	**(37)**
PERPETRATOR OF ABUSE/NEGLECT	40	49	40	3.01%	**(4)**
ABUSED/NEGLECTED CHILDREN	62	82	77	5.79%	**5**
SEXUALLY ABUSED CHILD	12	13	11	0.83%	**(2)**
FAMILY MEMBER OF ABUSED/NEGLECTED CHILDREN	37	30	22	1.65%	**(11)**
PARENT CHILD CONFLICT	32	37	41	3.08%	**7**
DELINQUENT STATUS OFFENDER	121	131	107	8.05%	**(19)**
FAMILY MEMBER OF DELINQUENT STATUS OFFENDER	8	7	4	0.30%	**(4)**
INFANT DEVELOPMENT PROGRAM	81	94	77	5.79%	**(10)**
TOTALS	**1,318**	**1,480**	**1,330**	**100.00%**	**(69)**

YOUTH DELINQUENCY

~It is important in our response to delinquency to understand the differences between one time offenders, multiple offenders, and youth who have committed crimes, and behavior that is dangerous to others in the community.~

Youth Delinquency in Wisconsin is defined as behavior by a person under 17 years of age who violates State or Federal criminal law. As the reader will note by the information contained in this section, a good deal of the delinquent behavior that is seen in Jefferson County is a one time occurance. A relatively small number of youth however are repeat offenders, who sometimes committ very serious crimes, or are engaged in multiple crimes over longer periods of time.

It is important in our response to delinquency to understand the differences between one time offenders, multiple offenders, and youth who have committed crimes, and behavior that is dangerous to others in the community. It is also important to understand the life circumstances and history of the youth and families that we work with. It is well known that child abuse, parental issues such as drug/alcohol addiction, parental absence, learning disabilities, and mental health problems on the part of the youth, all can contribute to delinquent behavior.

One of Jefferson County's responses to this important social issue has been to form a *Delinquency Prevention Council.* Established in late 1996, the Council is comprised of a wide variety of community members including law enforcement, the court system, schools, service agencies, clergy, businesses, community-at-large members and representation from local government including the County Board. The broad purpose of the Council has been to create an awareness and understanding of delinquency, its causes and effects and then to move to build best practice methods to deal with it in Jefferson County. To date, a number of significant system improvements have been planned and implemented by the Council including prevention programs, intervention methods to deal with the varying degrees of delinquency, and community education and strategic planning. A significant number of delinquent youth are involved in programs operated by our Council known as *Restorative Justice Programs.*

These programs are presented on the following pages along with some information on outcomes and numbers of youth involved. As will be noted, the lead agency for the Council is Opportunities Incorporated, which provides administrative oversight and programming in a number of these programs.

Restorative Justice Programs

Teen Court - 1998, Teen Court has continued to grow each year, and in total has held 552 youth trials. In 2008, we received 38 referrals for Teen Court. Six of those 38 referrals were closed before being set for trial for reasons such as family relocation or student disinterest, leaving 32 cases set for trial. Eleven of those 32 cases are still open in 2009, leaving 21 cases closed in 2008. Nineteen of the 21 cases set for trial closed successfully, resulting in a 90.5% success rate. In 2009 there are plans to expand the school-based Teen Court program into a high school setting, as well as recruit more volunteer judges for the community based program.

Service-to-Community

Since 1997, 1,690 youth have been referred to the service-to-community program and 25,457.5 hours of service-to-community have been performed in Jefferson County. 1,166 youth have completed their orders successfully, resulting in a 69% successful completion rate since 1997. We currently offer 15 different regularly scheduled supervised services-to-community sites for youth to attend across the county, with 11 sites per week on average.

In 2008, the 110 youth of Jefferson County who were referred completed 959.5 hours of service-to-community.

In 2009, we hope to integrate more service learning opportunities for the youth in our programs.

Restitution

Since 1996, 568 of the 851 youth referred to pay restitution have successfully completed their court ordered commitments, resulting is a success rate of 67%. Over that time period $222,305 dollars has been collected in restitution. Continued collaboration between the Restorative Justice Program, Jefferson County Department of Human Services, and Jefferson County District Attorneys offices, contributed to the successful collection of $13,905.11 dollars in restitution. This money was collected and repaid to the victims of crimes, in order to compensate for monetary damages caused by the juvenile.

Victim Offender Conferencing

Since 1997, we have held 58 Victim Offender Conferences. In 2008, the Restorative Justice Program received seven referrals and found three of those cases to be eligible for conferencing, based upon the criteria. Two of the three conferences used a volunteer victim. Of the four non-conferences, two of the referrals were closed due to extenuating circumstances (example: family relocation) and the other two referrals had an uninterested victim. In 2009, the Restorative Justice Program will continue to recruit volunteer victims and encourage uninterested victims to write an impact statement.

Fort Atkinson Probation Program

Since, 2005, the Fort Atkinson School District has collaborated with the Restorative Justice Program to provide services to youth who commit alcohol and drug related offense on school grounds. Since 2005, the Restorative Justice Program has had 36 youth referred to this program for community service completion and 22 youth referred for ATODA Awareness class completion, for a total of 39 youth served (not all youth receive both sanctions). In 2008, there were six youth referred to the Fort Atkinson Probation Program. There is one student currently participating in the ATODA class to finish his obligations in 2009 and one student was removed from the program due to relocation. Of the remaining four youth, three completed the program successfully, providing a success rate of 75% in 2008.

Mentoring Program

The Juvenile Mentoring Program, also known as JUMP, continues to make an active commitment to match at-risk youth with positive role models throughout Jefferson County. In 2008, ten youth participated in the mentoring program, spending quality time with a safe adult in the community. In 2008 the JUMP program held two mentoring events, in an effort to provide free and fun activities for the mentor and youth. In the fall of 2008, the JUMP program hosted a bowling event, and in the summer of 2008, the JUMP program hosted a picnic.

Panther Court

2008 initiated an exciting new partnership between the Watertown Unified School District and Opportunities, Inc. with the start of "Panther Court" at Riverside Middle School. Panther Court is a school based teen court used as an alternative discipline option that links students, teachers and parents. In 2008, four cases were tried successfully.

EDUCATION PROGRAMS

First Offender Program

In 2008, 19 youth were referred to the First Offender Program. Of the 19 youth referred, 15 of them successfully completed the class with a success rate of 78.9%.

Alcohol, Tobacco and Other Drug Abuse (ATODA) Awareness Program

In 2008, 18 youth were referred to the ATODA program, with two carryovers from 2007. Of these 20 possible participants, 6 were withdrawn from the class before commencement for a variety of circumstances, leaving 14 possible participants. Of these 14 participants, 5 cases are still open on 2009, leaving 9 youth enrolled in the ATODA class in 2008. Eight of the 9 youth enrolled completed this program successfully. This is an 88.9 % completion rate.

Anger Management

Of the 16 youth referred to Anger Management, two were withdrawn by their case managers before the class began and two are currently on the waiting list to take the next class, leaving 12 youth who participated in the class in 2008. Of these 12 referrals, 10 of them successfully completed the class, with a success rate of 83%.

Employability Skills Training

Employability Skills Training is a newly offered educational class for 2008. In partnership with the Alternative Learning Center in Watertown, it was determined that there was a need to offer an employability skills class, in an effort to assist students in meeting the HSED guidelines. Since it's inception in October of 2008, 14 youth were referred to the Employability Skills Training. Two class sessions and 18 individual meetings were held with students. Two students successful acquired employment after completing the training.

YOUTH DEVELOPMENT ACTIVITIES

Suicide Prevention Summit

On October 8, 2008 the Delinquency Prevention Council in partnership with the Jefferson County Health Department hosted a county-wide Suicide Prevention Summit. The goal of the Suicide Prevention Summit was to educate parents and service providers on suicide prevention, general suicide facts and intervention techniques for lay people. The Summit boasted 56 service providers and parents. The day long summit consisted of three presentations, in an effort to provide the attendees with a comprehensive perspective on suicide prevention.

Children's Care and Share Fair

The Children's Share and Care Fair started in 2001 and each year has been more successful than the previous year. In 2008, the Fair was held at Fort Atkinson High School on March 29th from 9am-

12pm. With a wonderful attendance rate, there were over 175 children between birth and age 11, who received a gift bag filled with coloring books, resources for parents and a healthy snack. Based on a survey, approximately 99 parents attended the Fair with their children and 100% of them indicated they would attend next year.

Red Ribbon Week

In 2008, the Delinquency Prevention Council, along with three school districts in the county launched a Red Ribbon Week Social Norms Campaign. Each of the three participation school districts worked with their students to creat a social norms poster using the most recent Search Institute data to bring awareness to the false perceptions that exist amongst middle and high school students surrounding alcohol, tobacco and drug use. The posters were printed, distributed and displayed for the entire month of October, promoting the positive message captured in each project.

Internet Predator Education for Parents

In cooperation with the Fort Atkinson School District, the Delinquency Prevention Council hosted Eric Szatkowski to speak to Jefferson County families regarding the dangers of the internet on April 30, 2008 at Fort Atkinson High School. Eric is a Special Agent with the Wisconsin Department of Justice/ Division of Criminal Investigation (DCI) since 1991. Eric's dynamic presentation on Internet crimes against children, entitled "The Dark Side of the Internet", has been seen by more than 140,000 people in Wisconsin and the U.S.

In Our Own Backyard: Gangs of Jefferson County

On September 23, 2008, two presentations were hosted at the Watertown High School, one for English speaking families and one for Spanish speaking families. On September 29, 2008 a parent presentation was also held at Lake Mills High School. Topics included, general information about gangs, clues that your child may be gang involved, prevention and intervention for families with gang involved youth, and helpful resources for parents.

Gang Summit: A Jefferson County Perspective

In the fall of 2006, a Gang Seminar was held in Jefferson County. This seminar was very successful and due to popular demand, a second seminar was held on March 11, 2008. This conference targeted the ever changing gang warning signs, markings and tags, in addition to addressing the direct gangs that are infiltrating Jefferson County. This summit was well received with approximately 60 community members in attendance.

Adolescent Brain Development Series

This year, The Delinquency Prevention Council hosted a four part series entitled "Understanding the Millennium Employee", presented by Mary-Adele Revoy of the Wisconsin Council on Children and Families. This series was an opportunity for employers, temporary employment agencies, parents and service providers to discover important information and how it relates to adolescents 13-25 and employees of the millennium generation.

ACCOMPLISHMENTS

100 Best Communities for Young People

Jefferson County was recognized as one of the 100 Best Communities for Young People by Americas Promise Alliance in 2008.. The *100 Best* competition recognizes the 100 outstanding communities across America—large and small, rural and urban—that are the best places for young people to live and grow up. In Wisconsin, Appleton/Fox Cities, Crawford County, Green Bay Area, Jefferson County and the city of Waukesha were named a few of the *100 Best* community because of the community's commitment to tackling the challenges facing its young people. A state wide recognition event in honor of the five Wisconsin Communities who were winners of the 2008's 100 Best Communities for Young People competition, nationwide was coordinated by the Delinquency Prevention Council. This event took place at 11:00am on June 25th, 2008 in the Assembly Parlor at the State Capital. Lt. Governor Lawton spoke on behalf of the State, recognizing these communities for their local efforts and state-wide efforts to boast Wisconsin's dedication to youth.

Jefferson County was selected because of the counties reputable level of collaborative efforts focused on positive youth development and delinquency prevention efforts. Other community collaborations include, but are not limited to the ATODA Partnership, which facilitates county-wide alcohol, tobacco and drug abuse education for young people, Dialogue for Student Success, which promotes community connectedness, information sharing and mobilization of the community for the betterment of youth, 3CUD, which promotes environmental strategies to provide kids with drug-free celebrations and the Delinquency Prevention Council which facilitates adult and teen focus groups, substance abuse education classes, and a social norms campaign.

NEW FOR 2009

Parents Who Host, Lose the Most Campaign

Many well-meaning parents think that it is enough to take away car keys at their teen's parties so the teens can't drink and drive. Parents provide the alcohol or allow alcohol to be consumed based on the false belief that it's a rite of passage, especially at prom and graduation parties. The "Parents Who Host, Lose The Most: Don't Be a Party to Teenage Drinking" public awareness campaign was developed by Drug-Free Action Alliance in 2000 to educate parents about the health and safety risks of serving alcohol at teen parties and to increase awareness of and compliance with the Ohio Underage Drinking Laws. This fall, the Delinquency Prevention Council will launch a county wide campaign, educating parents about the dangers of hosting underage drinking parties.

Internet Predator Prevention Presentation for Youth

On March 12, 2009, Eric Szatkowski will be returning to Jefferson County to fulfill the second step of our Internet Safety initiative. In a presentation entitled "The Real World of Internet Predators, Perverts, and their Prey", Eric will be providing county 7-12th graders with important information that will be key to keeping them safe when using the internet. This presentation shares much of the same information as The Dark Side of the Internet, but in a way that is appropriate for middle and high school students. Young people will learn from real case examples how to avoid being victimized online, and what they can do if something happens. They will also be shown how the dangers they learned about as children are just as important today when they use the Internet, as they become

young adults. Most important, students will learn the risks of making themselves available to predators on the Internet, including advice on social networking sites like My Space and Facebook, and online gaming sites such as X-Box Live.

Victor DeNoble Presentation

In cooperation with the ATODA Partnership, DPC will have the pleasure of presenting Dr. DeNoble, who was a driving force in the Wisconsin Tobacco Settlement in 1994 to the youth of Jefferson County again this spring. On May 4th and 5th, 2009, area 5th and 6th graders will hear the turbulent tales of DeNoble's work with tobacco giant Phillip Morris, who was recruited in the 1980's to develop a heart safe cigarette that would have the same addicting effects of nicotine. DeNoble speaks of his top-secret laboratory on the third floor of the Phillip Morris building where he did brain experiments on rats, a capuchin monkey and a 63-year-old former smoker, and discovered that nicotine changes brain chemistry. Dr. DeNoble speaks to thousands of middle school and college students every year, sharing his message about the dangers of cigarettes and how his research changed the tobacco industry forever, and we are very fortunate to welcome him back to Jefferson County!

For persons interested in additional information, the website for the Jefferson County Delinquency Prevention Council is www.helpingkidsnow.com

Law Enforcement Youth Delinquency Referrals

The following tables and charts provide summary information on referred youth.

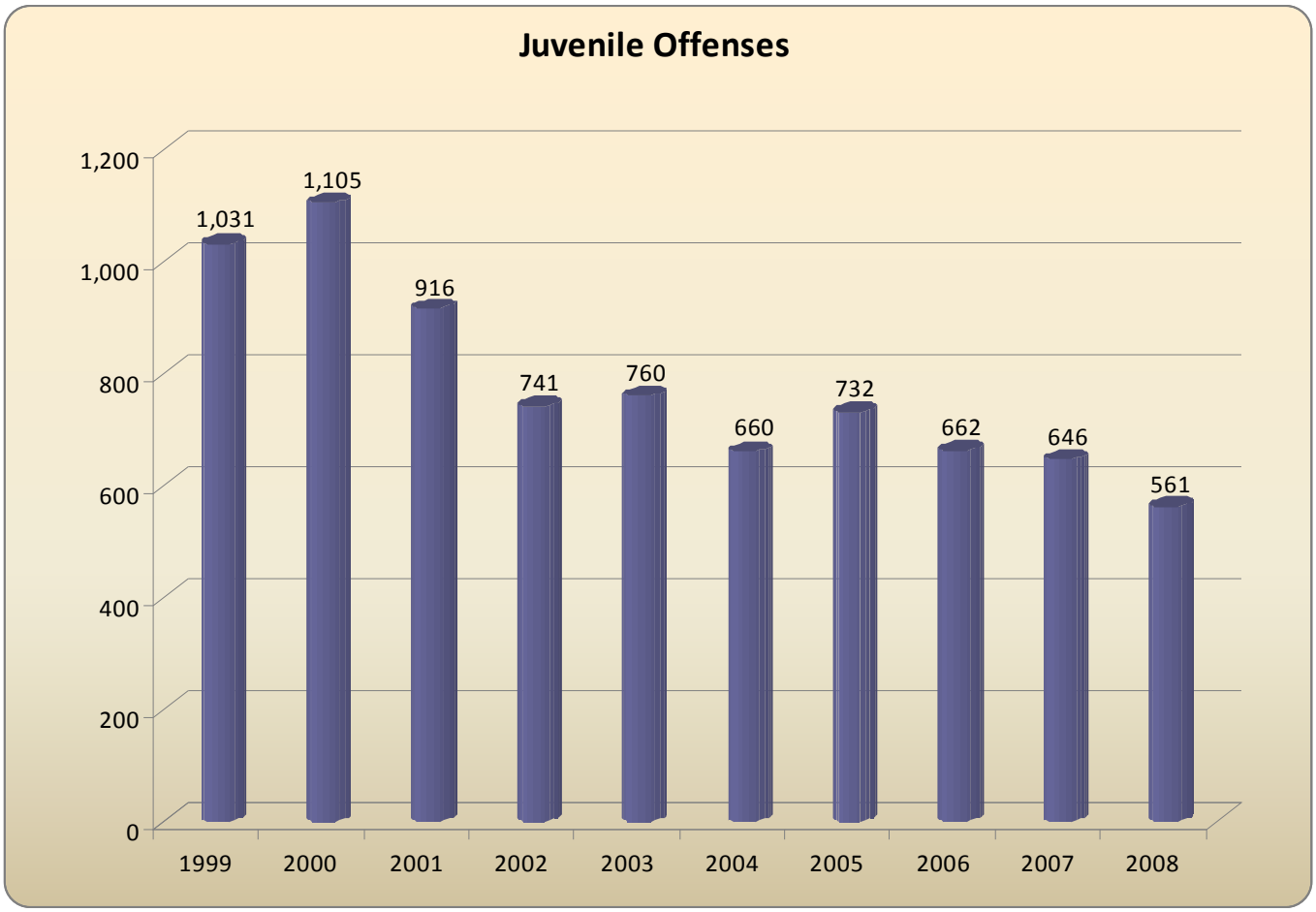
2008 Multiple Juvenile Referrals by Age

		Age <11	Age 11-12	Age 13-14	Age 15	Age 16	Age 17	Total Juveniles per # of Arrests	% of Total
Referrals	**1**	11	16	49	29	22	1	**128**	**52%**
	2-3	6	13	23	18	20	0	**80**	**33%**
	4-5	0	0	8	6	3	0	**17**	**7%**
	6-8	1	0	7	3	1	0	**12**	**5%**
	9+	0	0	4	1	2	0	**7**	**3%**
Total Juveniles with Multiple Referrals per Age		**18**	**29**	**91**	**57**	**48**	**1**	**244**	**100%**

2004-2008 Juvenile Intake by Age

	Age <11	Age 11-12	Age 13-14	Age 15	Age 16	Age 17	Total Youth
2004	18	34	96	68	69	5	**290**
2005	9	40	98	65	81	10	**303**
2006	23	30	71	73	73	1	**271**
2007	10	26	90	47	64	3	**240**
2008	18	29	91	57	48	1	**244**

Juvenile Offenses									
1999	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
1,031	1,105	916	741	760	660	732	662	646	561



POLICE REFERRALS for JUVENILE OFFENSES

1 and 5 Year Comparisons

OFFENSES (1997-2001)	2008	2007	1 Year (2007-2008) Increase/Decrease	2008	2004	5 Years (2004-2008) Increase/Decrease
Alcohol/Tobacco	1	12	**(11)**	1	6	**(5)**
Arson	3	5	**(2)**	3	7	**(4)**
Battery	42	37	**5**	42	41	**1**
BurgleryRobery	18	32	**(14)**	18	30	**(12)**
Burning Materials/Fireworks/Explosives	1	7	**(6)**	1	0	**1**
Contempt of Court/Violation of Court Orders	2	8	**(6)**	2	13	**(11)**
Crimes Against Children/Other	16	7	**9**	16	18	**(2)**
Criminal Damage to Property	30	45	**(15)**	30	51	**(21)**
Criminal Trespass	7	37	**(30)**	7	12	**(5)**
Disorderly Conduct	138	135	**3**	138	139	**(1)**
Drug Related	71	90	**(19)**	71	117	**(46)**
Fleeing/Escape	8	8	**0**	8	8	**0**
Forgery	4	4	**0**	4	5	**(1)**
Intimidation/Harrassment	5	6	**(1)**	5	3	**2**
Obstructing/Resisting Arrest	30	33	**(3)**	30	17	**13**
OWVWOC/Other Vehicle	22	18	**4**	22	11	**11**
Receiving Stolen Property	2	2	**0**	2	1	**1**
Reckless Endangerment	1	3	**(2)**	1	5	**(4)**
Sex Offense	57	34	**23**	57	59	**(2)**
Theft	56	90	**(34)**	56	73	**(17)**
Truancy	34	21	**13**	34	30	**4**
Weapon Related	13	12	**1**	13	14	**(1)**
TOTALS	**561**	**646**	**(85)**	**561**	**660**	**(99)**

<u>The following summary statements highlight the charts above.</u>

- 244 different individuals were referred for a total of 561 offenses. When comparing 2007 and 2008, the figures show a increase of 4 individuals and a decrease of 85 offenses. Overall, when comparing youth total offenses, 2008 is the lowest year on record.

- 57% of the total referred youth are 14 or younger.

- 15% of youth were referred four or more times and 8% were referred six or more times.

- 19 youth were referred at least six times and 7 youth were referred nine or more times. This represents 11% of the total, a drop of 1% from 2007. This also generally indicates the proportion of youth who are considered as serious or chronic delinquents who require our most intensive services in terms of time and costs. This population of youth has been declining, which indicates that continued efforts at earlier intervention to reduce youth becoming chronically delinquent are effective and need to continue.

- Following National and State trends delinquency referrals in Jefferson County have continued to decline over the past decade. As noted in prior reports, we believe our contribution to this is the work of the Jefferson County Delinquency Prevention Council which has promoted and emphasized best practice models. This community collaborative work has included prevention, community based work to strenghthen and support families, the work of Restorative Justice Programs as noted above, and the work of the Delinquecy Team at Human Services, which continues to provide treatment, supervision, and community based work for our most involved youth and their families.

As noted on the chart below, offenses which are considered, "Juvenile Crimes of the Greatest Concern", represent 49% of the total number of offenses referred. Truancy referrals are removed in this statistic. This is 4% more than was seen in 2007, (39%), but is consistent with the long term trend. Readers will note that by far the most commonly seen offenses continue to be drug offenses. This issue continues to be addressed by the work of the Prevention Council in terms of promoting and providing community and school based education and treatment. Planning is currently underway for a Teen Drug Court in Jefferson County. Violent juvenile crime in Jefferson County is a very low overall percentage, which has been a long term positive trend.

JUVENILE CRIMES OF GREATEST CONCERN FOR THE YEARS 2004-2008

OFFENSES	2004	2005	2006	2007	2008	Percent 2008
Arson	7	2	2	5	3	2%
Battery	41	33	32	37	42	14%
Burglery	30	37	30	32	18	13%
Crimes Against Children/Other	18	13	9	7	16	3%
Drug Related	117	100	79	90	71	35%
OMVWOC/Other Vehicle	11	30	29	18	22	7%
Sex Offense	59	21	46	34	57	13%
Truancy	30	42	23	21	34	8%
Weapon Related	14	12	16	12	13	5%
TOTALS	**327**	**290**	**266**	**256**	**276**	**100%**

ALTERNATE CARE

~A major goal of Alternate Care is returning people to their natural home and community setting by providing a wide variety of mental health and social services.~

Our Alternate Care services provide access to a wide range of out-of-home placements for children and adults. Alternate care remains a very important priority service and great care is taken in making these placements. Placements are made with the intention of assisting the individual to return to the home setting. When this is not possible, long-term placement arrangements, such as group homes for developmentally disabled and elderly are provided. Individuals who need out-of-home placement require a great deal of social work time, effort and funding in order to successfully return to community living.

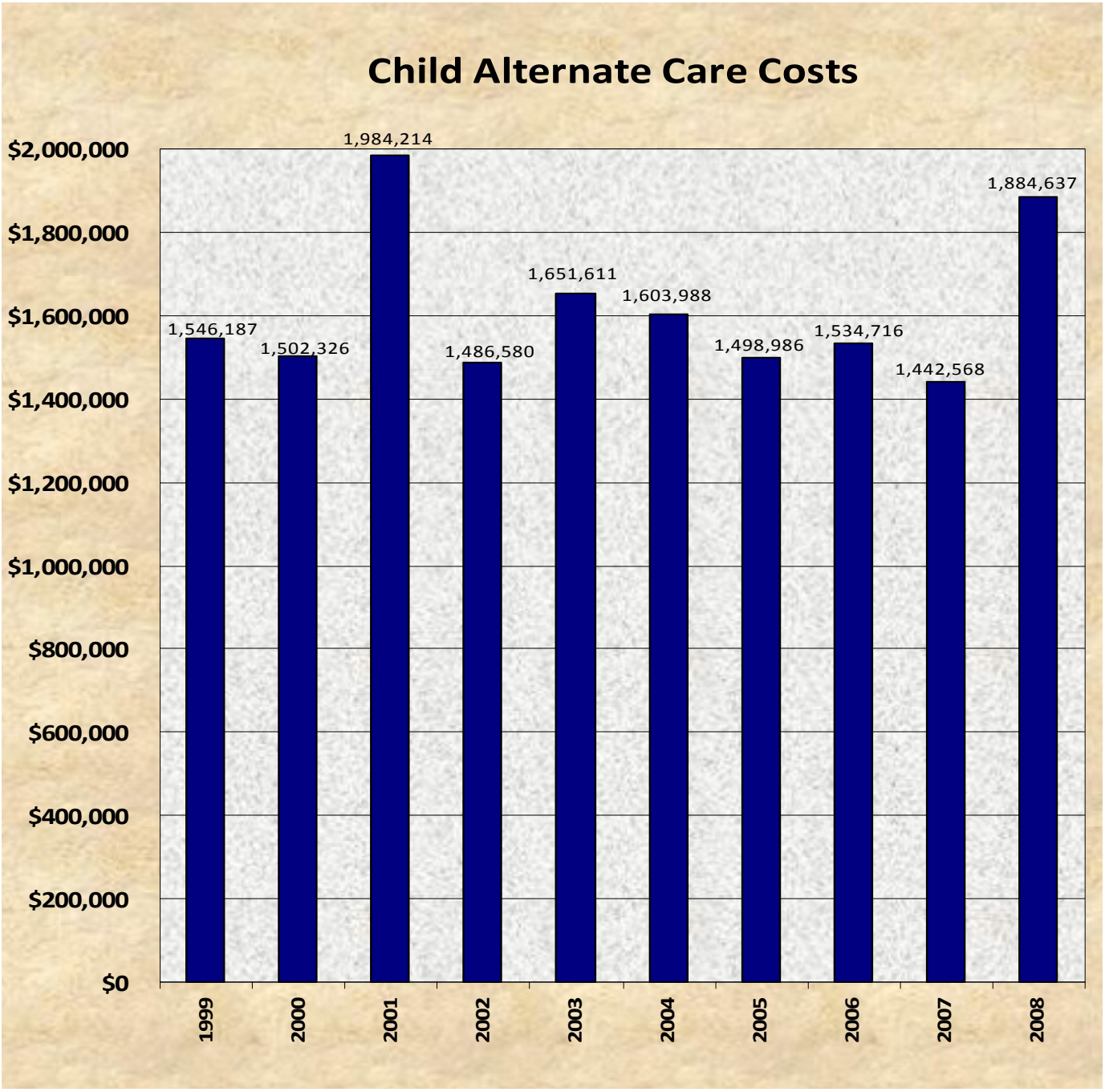
Alternate Care Philosophy

- Avoiding placements, particularly of children, whenever possible, by providing protection, support and services.
- Keeping placements short in duration and making them within the community whenever possible.
- Minimizing the use of institutional placements by creating packages of community services, including operating our own group homes.
- Returning people to their natural home and community setting by providing a wide variety of mental health and social services.

Child Alternate Care

Child alternate care costs remain a major concern to us, and a priority for new, increased and changed programming. The graph shown on the next page tracks the costs in this area for the past 10 years.

As noted on the following graph, our 2008 Child Alternate Care costs increased significantly over 2007, and in fact were the highest on record since 2001. Numbers of youth placed also increased significantly, particularly in out - of - county placements including residential treatment centers. A number of these placements were due to an inter-county transfer of ten children late in 2007 that carried through 2008. From time to time changes such as this, which are not in our control, occur. Additionally, as noted above, our use of out - of - county and residential treatment centers was much higher than average, which generally means that these youth in question have higher needs for structure and treatment. That said we are acutely aware that we need an increased focus on youth placements from treatment needs and cost perspectives. Increased use of programs including Comprehensive Community Services and Wraparound will continue to be considered for youth and their families in the Child Protection and Delinquency areas as these families come to us with significant mental health needs.



The following chart shows 93 youth from Jefferson County were placed in some form of out-of-home care during 2008, which is a decrease of 7 youth from 2007. Some required more restrictive placements in institutional settings; however we continue to take strong measures to avoid these. Because the needs of persons who require alternate care are high, programming efforts, particularly mental health services, to meets these needs, are used in conjunction with placements.

ALTERNATE CARE PLACEMENTS - CHILDREN							
PROGRAM	**2004**	**2005**	**2006**	**2007**	**2008**	**2008**	**2008 Total**
					Male	Female	
Foster Care (In-County)	24	30	28	46	12	13	25
Foster Care (Out-of-County)					4	10	14
Treatment Foster Care (In-County)	6	12	7	7	2	0	2
Residential Care Center (Child Care Institutic	17	7	5	8	7	1	8
Child Correctional	4	3	1	1	1	0	1
Child Mental Health Institute	4	4	3	4	1	1	2
Out-of-County Treatment Foster Home	11	12	21	22	16	11	27
Out-of-County Group Homes	17	23	17	12	9	5	14
TOTALS	**83**	**91**	**82**	**100**	**52**	**41**	**93**
BREAKDOWN							
Black				10	1	8	9
White				87	45	28	73
Hispanic				0	4	4	8
American Indian					0	1	1
Unable to determine				3	2	0	2
TOTALS	**83**	**91**	**82**	**100**	**2**	**41**	**93**

Another initiative which was begun in 2002 is the ***Jefferson County Wraparound Project.*** This project continues to serve children and families from all of the communities in our county. Approximately 40 of our highest need children and families are enrolled in this project at any given time. We refer to this as a "project" because it is a shared endeavor with the whole community. The Project is governed by a representative group of community members from schools, police departments, community mental health providers, ministers, parents, and interested others. Guidelines have been established for referral process and how all members of the project will cooperate to share responsibility for helping families. Each family in the project has a "team" of community members and appropriate helping organizations who work with the family to develop and carry out a plan of care to meet the family's needs and address the concerns in question.

A number of other Departmental programs also provide substantial care and support for families and children. These include; ***Community Outreach***, which provides high levels of in-home community based support, guidance, education, and supervision; ***Intensive Supervision***, which provides daily contact for youth on strict court ordered supervision; ***Life Skills Program***, which teaches young adults basic living and coping skills; and ***Housing***, which specializes in working with clients that are experiencing a housing emergency or need. All of these programs concentrate on structuring successful community living, positive school or work attendance, family and youth treatment, mentoring and education, and community service and restitution for those youth

where this is required or appropriate. More detailed information, including outcome measures and yearly planning efforts are available by contacting the Human Services Department.

Independent Living Program

The Independent Living Program is a partially Federally sponsored program for young adults in placement to help them enhance personal daily living skills that will help them become independent, responsible and productive members of society.

Detention Placements

A final related statistic in the Child Alternate Care area is our use of secure detention (locked juvenile jails) for youth. During 2008, 108 youth were placed in these facilities at a cost of $64,269. This continues to be a substantial increase from 2006 when 58 youth were placed at a cost of $30,885, and unfortunately follows the 2008 trend of significantly increased costs for youth out - of - home placements. These placements are either made by the Juvenile Court or by Human Services staff in order to provide community protection or to consequence youth for violation of a court order.

Adult Alternate Care

Human Service's Adult Alternate Care program provides care for individuals who present life struggles such as mental illness, alcohol or drug dependency, developmental and physical disabilities or infirmities of aging. As noted in the philosophy statements of alternate care, our goal is to assist individuals to live with support and dignity in the community whenever possible.

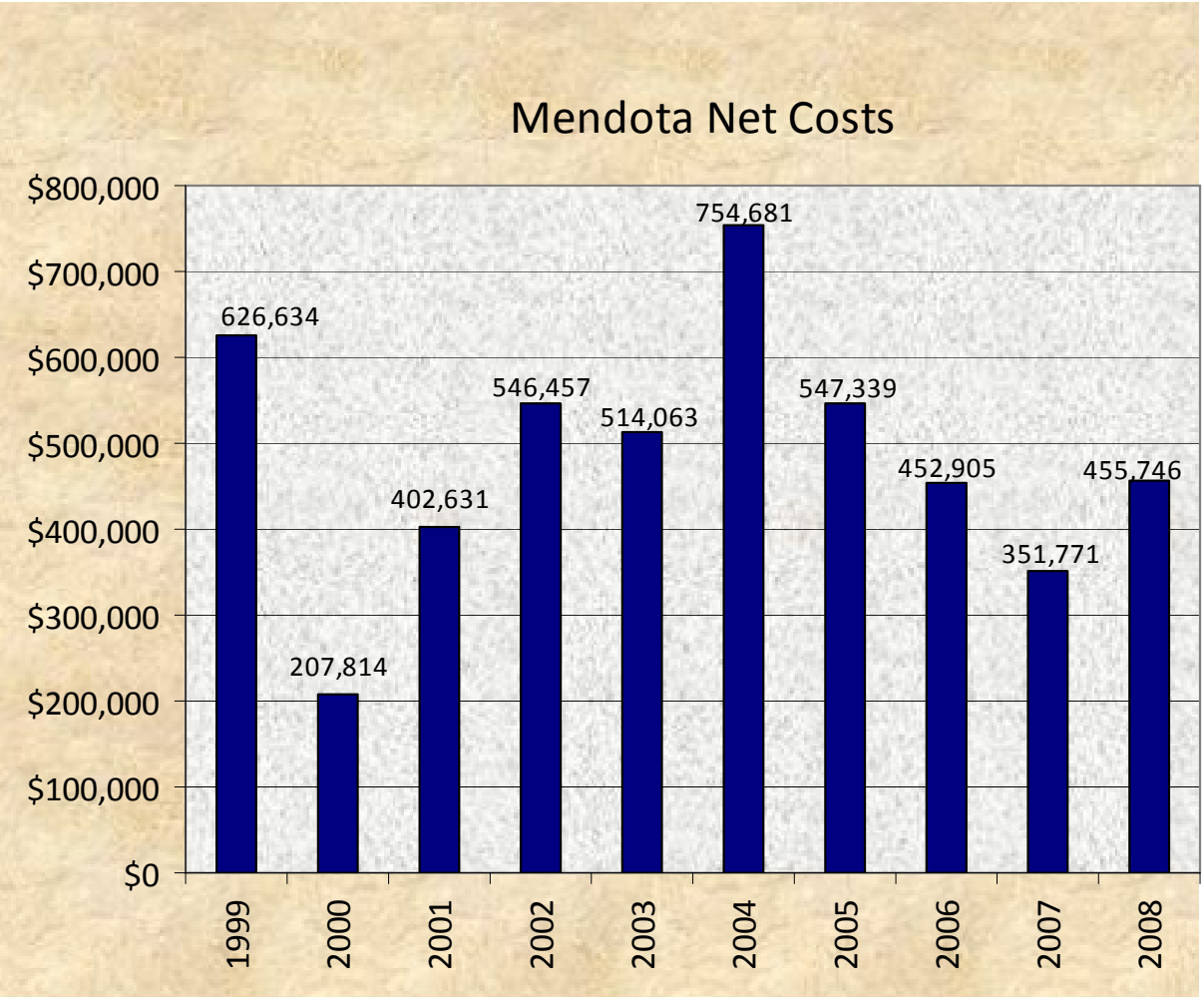
Lueder Haus

The Lueder Haus is a group home facility caring for individuals with a serious mental illness. It was opened in 1995 and named after our former Board Chair, Richard Lueder. This facility provides a high level of mental health care including psychiatric care, therapy, daily living skills, recreation, socialization, aftercare and supervision to individuals who may otherwise be hospitalized. We also use Lueder Haus to assist individuals to return to their homes after a hospitalization. During 2008, there were 172 admissions of 84 different individuals to Lueder Haus. This is a decrease of 10 people when comparing to 2007. As noted in past reports, Lueder Haus is a highly successful program which allows many County residents the freedom and dignity to manage their illness while remaining in the community.

The following chart provides summary numbers for adult alternate care placements.

ADULT PLACEMENTS				
PROGRAM - (In County)	2005	2006	2007	2008
Lueder Haus	163	178	217	172
READMISSIONS	79	94	123	88
Developmentally Disabled	230	228	303	290
Elderly	35	31	55	55
Physically Disabled	19	15	24	23
AODA	2	0	0	0
Mentally Ill	46	36	33	31
PROGRAM - (Out of County)				
Developmentally Disabled (Group Homes)	15	11	13	15
Elderly (Group Homes)	29	32	41	27
Physically Disabled	10	5	6	6
AODA (Group Homes)	14	6	7	18
Mentally Ill (Group Homes)	9	5	6	9
HOSPITALS				
AODA Detoxification	81	84	46	65
Mental Health Institutions	115	80	70	74
Private Psychiatric	8	3	5	4

The graph on the following page isolates psychiatric inpatient costs at Mendota Mental Health Institution for the past 10 years, from 1999 to the present. As the graph indicates, this is an important and volatile area. Costs are difficult to predict due to the nature and circumstances of persons who are mentally ill and require treatment and protection. Consequently, significant efforts are made to provide community based treatment as an alternative to hospitalizations. These include our Lueder Haus program as described above and our Community Support Program, which follows. Overall, 2008 was a successful year in terms of improved treatment programming and reducing hospital costs. Our 2008 hospital costs were within planned costs for this area for 2008. This was accomplished by the continuing use and development of our Community Support Program, Comprehensive Community Services Program, and Emergency Mental Health Program. Detailed results for these programs follow.



MENTAL HEALTH

Mental Health/Alcohol and Drug Outpatient Clinic

~ Services are provided in the least restrictive setting providing; decreasing the disruption of the individual's life while still providing for recovery.~

The Programs

The Mental Health/Alcohol and Drug Outpatient (AODA) Clinic (HFS 75, HFS 61) serves adult Jefferson County residents with mental health and substance abuse concerns. Participants of the program are assessed for strengths and needs, and a treatment plan is developed to address the needs of the individual. Services are provided in the least restrictive setting providing; decreasing the disruption of the individual's life while still providing for recovery.

In 2008 there were 182 new mental health consumers opened to the clinic, 516 AODA consumers were opened, including all the individuals who came for driver safety assessments. A total of 633 persons received services from the clinic in 2008.

The clinic employs six full-time staff with master's degrees in Social Work, Counseling or Psychology, one of whom works part-time in the jail, two full-time staff certified as Alcohol and Drug Counselors, a part-time Community Outreach Worker and a full-time intake worker.

There was significant staff changeover in 2008. A new supervisor was hired in June. Three new staff was hired between July and September 2008 to replace workers who left. One senior employee was also gone for a leave of absence. There was a 2 month period in which the clinic was understaffed.

Other changes included becoming part of the Behavioral Health Division under the leadership of a manager. This provided an opportunity for the clinic to be an active part of the continuum of services for mental health and AODA consumers.

The principles of recovery were emphasized and integrated into the clinic service. Staff was trained in the philosophy of recovery and importance of consumer directed services. Treatment plans were reformatted to reflect the individual's participation in the planning process.

New mental health groups were started in 2008; one for depression and one for anxiety. The majority of staff participated in a five day motivational interviewing training towards a goal of integration of the skills in practice.

The clinic is also responsible for overseeing civil commitments and in many cases, providing treatment for the individual. Under WI § 51, persons who are assessed to be dangerous to themselves or others and have a mental health disorder may be detained involuntarily. If the court determines that these persons need to be treated, they are placed under an order for treatment, usually for 6 months. The person can seek treatment from the clinic, or if the person has other resources by another area provider. The clinic (the 51.42 board representative) is responsible for supervising the commitment period and insuring that the individual is following through with the treatment recommendations regardless of where treatment occurs.

Chapter 51 also provides for a three party alcohol commitment. As for the mental health commitment, if the court determines that the person meets the criteria, they can be placed on an alcohol commitment requiring them to participate in AODA treatment. Again, that treatment can be provided by our clinic or another clinic in the community. The clinic staff is responsible for supervising the person to ensure they are following through with treatment recommendations. In 2008, 114 new commitments were obtained.

Emergency Mental Health, (HFS 34) is a new program provided under the clinic. Under WI. § 51.42 all counties are required to provide emergency mental health (EMH) services to persons within the county who are experiencing a mental health crisis or are in a situation likely to turn into a mental health crisis if supportive services are not provided. In 2007 the department was certified operate an EMH program under HFS 34. All clinic staff were trained in EMH services, policies and procedures of the program.

Target Case Management (TCM) is a Medicaid program under HFS 105.51, to provide case management to eligible participants. The Case Facilitator assists recipients in *gaining access to* and *coordinating* a full array of services, including medical, social, educational, vocational and other services. The services to be accessed are based on a comprehensive evaluation and a service plan that is developed by the case facilitator and the consumer.

In 2008, the Targeted Case Management program was integrated more seamlessly with the clinic. The assessment tool used in the clinic was adapted to also meet the assessment needs of the case management requirements. The case plans were changed to more accurately reflect the goals and services being sought. A chart index was modified to help assure that all the paperwork requirements were meet for the TCM program.

Intoxicated Driver Program is mandated under HFS 62. Each county is responsible for establishing and providing assessments of drivers ordered by the court and development of a driver's safety plan based on the completed assessment. The clinic has two IDP assessors who provide all IDP assessments and driver's safety plans for Jefferson County. In 2008 the IDP program completed 417 assessments and driver's safety plans.

Consumer Satisfaction

In 2008, the Outpatient Clinic conducted a consumer satisfaction survey. The ROSI (Recovery Oriented System Indicators) measures the satisfaction of the participant and the degree to which its services are recovery oriented.

We had twelve respondents, of the 63 surveys sent; a 19% return rate. Unlike other programs, the clinic does not provide an incentive for returning the questionnaire.

The survey asks 42 questions regarding the participant's experiences in the past six months. The choice of responses range from strongly disagree to strongly agree and includes an option of does not apply to me. The questions rates 6 areas of service: Person Centered Services, Barriers to success, Empowerment, Employment, Staff Approach and Basic needs.

Four scales were positively worded meaning a higher score represented a more recovery oriented experience.

Two scales were negatively worded meaning a lower the score represented a more recovery-oriented the experience.

Survey Discussion

Person-centered and empowering the consumer were both strongly endorsed in the survey. The staff approach area was negatively impacted by the statement "staff lack up-to-date knowledge on the most effective treatment". This will be addressed in the goals section. Barriers to treatment will also be addressed in the goals section below.

Two other areas to examine are basic needs and employment. Basic needs ask about having enough income to live on and housing they can afford. In these difficult economic times we have seen a dramatic increase in individuals who have lost jobs, insurance and sometimes housing. They are impacted at a time when there is a reduction of resources at all levels for assistance. These are issues that are larger than what can be addressed at an agency level.

2009 Goals

	Level of Recovery Orientation		
	High	Mixed	Low
Person Centered	72.2%	18.2%	9.1%
Empower	75%	25%	
Employ	54.5%	36.4%	9.1%
Basic Needs	50%	30%	20%

	Low	Mixed	High
Barriers	8.3%	83.3%	8.3%
Staff Approach	50%	33.3%	16.7%

The over arching theme for 2009 goals is improved accountability for results and increased consumer satisfaction.

- **Increase consumer choice by increasing the number and type of services.**

Consumers did not feel they had enough services options available to choose from. Consumers should have different options based on their needs and strengths. The clinic will increase the number of mental health groups currently being offered. In addition to the depression and anxiety groups offered, groups for trauma, wellness and other identified areas will begin in 2009. In the AODA area, groups will be redesigned based on stage of change. Persons will be offered options based on where they are at in the process of change for their substance use. A group for people with a dual diagnosis, mental health and substance use, will begin in 2009.

- **Use of evidence-based treatment modalities.**

There is a great deal of research done in both mental health and alcohol and other drug treatment that identifies effective treatment protocols. Programs provided will be evaluated to see that they utilize components shown to be effective.

- **Increase consumer access to services in a timelier manner**

Consumer's responses on the survey indicated they wanted to access services more quickly. This will be addressed initially by increasing the number of groups provided. A QI project to evaluate alternate methods to increase consumer access to services will be completed in 2009.

- **The Intoxicated Driver Program will become self funded.**

The IDP program charges for assessments. The goal will be for the assessment fees to pay for the total salary for both assessors. This will be accomplished by increasing the number of assessments done each week and decreasing the no show rate.

- **Quality assurance and Quality Improvement.**

Quality improvement and assurance will be integrated into the clinic programs. A quality improvement team will be developed, composed of both management and staff to assess quality in various aspects of service provision. All groups will have an assessment component integrated into treatment to determine best outcome. A system for evaluating of treatment plans and notes for quality will be developed and put into place.

- **Development of a training program to address new and current employee training needs.**

A new employee training handbook with be developed to ensure adequate training in all areas of the clinic.

Assessment of current employees needs will be done periodically and training resources will be offered through in-house staff and web based training sites including the agency's mental health training site.

- **Monitoring productivity of staff.**

Staff's productivity will be monitored by a weekly review of their daily time sheets. The goal for all staff will be 80% direct and collateral consumer directed service.

- **Outpatient clinic policy and procedure manual will be updated.**

Community Support Program

~CSP has been successful in helping consumers meet their goals and enhance the quality of their lives in the most cost effective manner.~

The Jefferson County Support Program was developed in December of 1996 and began receiving clients in January 1997. This Community Support Program was certified on June 1, 1997 and is certified under HSS 63 as a Community Support Program. The program was audited by the state in May 2008 and was recertified for two years at that time.

In its eleventh year of operation the Jefferson County Community Support Program provided services to 118 consumers ranging in age from 22 to 76. These consumers had mental health diagnoses such as schizophrenia, schizo-affective disorder, bipolar, major depression and various anxiety disorders. In 2008, thirty consumers were admitted and eight were discharged.

Jefferson County Human Services CSP has grown significantly. In 1998 it served less than thirty consumers, and employed five and a half staff. In 2008 the CSP staff consisted of a CSP Director/Clinical Coordinator; psychiatrist/ medical director; program assistant; secretary; two full time and one part time mental health technicians one of whom was also a peer support specialist; one vocational specialist who began doing primarily these duties in September; one part time nurse; and eleven case managers/CSP professionals. One case manager position remained unfilled through-out the last quarter of the year.

Community Support Programs in the state of Wisconsin have an extensive and well researched history. The original CSP started out of Mendota Mental Health Institute in the 1980's and is now known as ACT. The ACT model has received numerous awards from the American Psychological Association for its research. It is now used on a nationwide and international basis to advance the mental health services for people with a severe and persistent mental illness. It has proven effective for reducing symptoms, hospital costs, and improving overall quality of life. The research has shown that for outcome measures to be similar for consumers in other CSP's it is important to have as much fidelity to the ACT model as possible. Jefferson County CSP continues to have very high fidelity to the ACT model and the team functions as an ACT team. It is believed that this led to better outcomes for our consumers.

In accordance with the ACT model, the Jefferson County CSP has the capacity to function as a mobile in-patient unit. The program provides psychiatric services, symptom management, vocational placement and job coaching, supportive counseling, opportunities for social interactions, individual and group psychotherapy, medication management and distribution, education and money management and budgeting, coaching

in activities of daily living, including how to maintain a household and homemaking skills, crisis intervention, case management and supportive services to people with severe and persistent mental illness. All consumers in the CSP, at some time, have had acute episodes that have resulted in the need for frequent psychiatric hospitalizations and emergency detentions to institutes for mental disease. Consequently, in the past, their lives were disrupted and they were removed from their community of choice. Presently, CSP services can be titrated up and down quickly as the need for more intensive treatment arises.

Jefferson County's CSP also provides consumers the evidence based practices (please see sections below for detail) of Illness Management and Recovery, Integrated Dual Diagnosis groups for those with substance abuse issues, Supportive Employment, Family Psychoeducation, Seeking Safety, and DBT. Consumers also are encouraged to complete Wellness Recovery Action Plans; these plans specify what is helpful for the person in a crisis situation and function similar to a psychiatric directive.

It is believed that due to these combined efforts the Jefferson County CSP was successful in helping consumers meet their goals and enhance the quality of their lives in the most cost effective manner.

Some of the specific accomplishments for the year 2008 include:

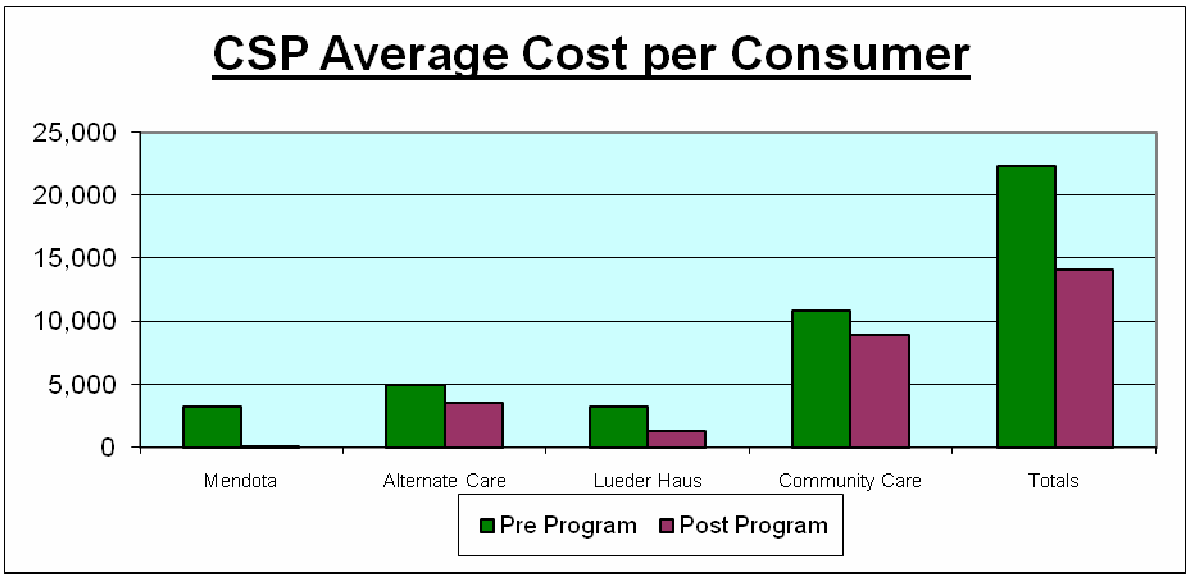
1. Seven consumers moved from alternate care placements, i.e. supported apartments, or adult family homes, to their own apartments.
2. Five consumers, who were on Chapter 51 orders, successfully completed their court requirements.
3. Three consumers resumed managing their own money as their skills were enhanced and the protective payeeships were dismissed.
4. Only five consumers were admitted to an Institute for Mental Disease, i.e. Mendota Mental Health Institute. Four were new emergency detentions.
5. Thirty four percent of consumers worked in a job of their choosing.
6. Fifteen consumers served the community through volunteer work at such places as Fort Atkinson Memorial Hospital, St. Vincent's, and Horizons Drop In Center.
7. Seven consumers pursued educational goals at UW-Whitewater, MATC, Herzing College, and Waukesha County Technical College.
8. All goals were met from last years report. These will be reviewed below in detail.

Financial Data for 2008

A variety of data has been compiled over the eleven years of our CSP's existence. This includes the number of days a consumer was at the Lueder Haus, Mental Health Institute or hospitals and the cost of these services. It includes a comparison of the costs of these

services for the year prior to being in CSP with the last year, 2008, of being in CSP. Other data included were: personal care worker costs, medication costs, alternate care placement costs, and staff costs. Costs compiled for the year prior to CSP admission are annualized to reflect what would be a more fair comparison with current costs.

When comparing costs in these areas for the full year prior to CSP services with the costs for these same services in 2008 for each consumer results in the $758,440 net savings from county dollars. The net county cost of services per individual in CSP decreased by 37.1%. This is based on the following cost reductions for CSP participants: institutional costs decreased by 95.8%; alternate care costs decreased by 27.7%; Lueder Haus costs decreased by 58.1%; Community service costs decreased 17.5% The following bar graph summarizes this cost analysis. This data will be used for quality improvement projects over the next year.



Goal number one: Hire and train a Clinical Coordinator/supervisor for our CSP; assure that this process is as smooth and seamless as possible for consumers and team members.

Internal candidate Marjorie Thorman was hired in May for the supervisor position at CSP. A training and transition period ensued. Marjorie had worked as a case manager in the program for over eight years so was familiar with all consumers and staff as well as the program itself. Continuity was also maintained since former CSP supervisor Kathi Cauley became the direct supervisor for the position. Kathi has provided close supervision and guidance throughout the year, and this has ensured a seamless transition for all involved.

Goal number two: Further implementation of person centered planning, i.e. review and revise documents; meet with one consumer that each team member works with in a ROSA type process to assure fidelity.

Person centered planning is a service plan process to assist the consumer in identifying goals and dreams that they want to pursue in their lives.

Person centered planning continued to be implemented and improved throughout the year. Service plans were updated and adapted to include consumer barriers in meeting their goals and areas of difference with the service team. Service plans reviews were reviewed as well to incorporate more of the modality. The consumer's completion of treatment plan goals rose from seventy-one percent in 2007 to seventy-six percent in 2008. The completion rate will continue to be monitored in the upcoming year.

We again decided to implement the Recovery Oriented System Inventory (ROSI). The ROSI is the result of a research project that included consumers and non-consumer researchers and state mental health authorities who worked to operationalize a set of mental health system performance indicators for mental health recovery. The ROSI was developed over several phases with a focus group of consumers who were able to develop a 42 item self report adult consumer survey. A factor analysis resulted in the domains of staff approach, employment, empowerment, basic needs, person centered, and barriers being able to be measured. The ROSI was found to be valid and reliable over the three phases of implementation.

Consumers of the CSP were sent a ROSI survey to complete anonymously. Fifty five consumers completed this survey up from thirty three last year. The following charts further explain the ROSI and summarize the results. The questions associated with scales 2 and 5 are worded negatively, so a lower mean is seen as more positive.

Means and Percentages for ROSI Consumer Survey Scales

	ROSI Overall Mean	Scale 1 - Person Centered	Scale 2 - Barriers	Scale 3 - Empower	Scale 4 - Employ	Scale 5 - Staff Approach	Scale 6 - Basic Needs
Average for All Consumers	3.4	3.5	1.7	3.3	3.0	1.4	3.2
% w/ Mostly Recovery-Oriented Experience	75.5%	84.6%	59.3%	85.2%	57.6%	87.0%	83.3%
% w/ Mixed Experience	22.6%	13.5%	37.0%	11.1%	33.3%	6.5%	12.5%
% w/ Less Recovery-Oriented Experience	1.9%	1.9%	3.7%	3.7%	9.1%	6.5%	4.2%

Note: Means can range from a low of 1.0 to a high of 4.0. However, item wording for the shaded scales are negatively phrased, so a low mean represents a more recovery-oriented experience (meaning the consumer disagreed with the negative statements.) The percentages in Rows 3-5 have been adjusted for Scales 2 and 5 so they have the same meaning as the other scales.

These results indicate that consumers feel empowered by CSP staff and person centered planning occurs. Further, consumers report liking the approach of staff and find that the barriers to seeking services they need are minimized. The employment scales reflects that more people are interested in working.

The clinical coordinator also conducted ten interviews to question consumers further about their satisfaction with services. The survey addressed their relationship with their worker, ways the CSP had met their needs and assisted them in meeting their goals, and things that could be improved on in the future. All ten consumers indicated that services have been helpful to them in various ways. Many identified that the program had assisted them in obtaining the goals they had set and living more independently in the community. Suggestions for improvement in CSP services included offering more groups for consumers to attend.

Goal number three: Expand our employment services by additional staff time for job development.

In September, a staff from another department was identified to work as a vocational specialist for the CCS and CSP programs. This individual was able to devote more time to assisting consumers in pursuing their vocational goals. The Community Support Employment Program provided a variety of vocational services for approximately 21 consumers this year. This program followed the evidenced-based model for supported employment. It also served as a vendor for individuals that were in the CSP, and were referred by the Department of Vocational Rehabilitation (DVR). As a vender of DVR services, the vocational specialist provided services related to vocational assessments, job placement, job coaching, benefit analysis, and job shadows, and assistance in arranging transportation.

Consumers receiving vocational support learned job skills to obtain and keep employment. They learned these skills through individual sessions and through experience with employers. Vocational assessments were provided. A number of consumers attended job shadows at a variety of places of employment in the community. Some of the places where consumers job shadowed were a day program for people with disabilities, a supported apartment complex, a landscaping job, a veterinarian's office and a library. Providing a job experience for consumers allows them to explore vocational interests, observe the skills needed for the position, and learn an employer's expectations.

Twelve of the 21 consumers served by the vocational program gained or maintained employment. With the consumers already working, forty one consumers had employment at some time throughout the year. This led to 34 percent of CSP consumers working; this exceeds the national average of people working who have a psychiatric disability. Some of the places of employment were at nursing homes, group homes, supported apartments for people with disabilities, restaurants, libraries, peer support specialists through human services, department stores, a taxi company and a spa. The positions that were filled in the community were: grounds maintenance, dishwashers, animal care taker, CNA, nail technician, golf course worker, custodian, group home worker, library assistant, taxi cab driver, sales assistant and dietary aide. Other consumers remained employed through Opportunities, Inc. until they could find community employment.

Furthering education continues to be a focus of the CSP vocational program. A total of seven consumers from the CSP attended post high school programs in 2008. One consumer attended UW-Whitewater for marketing and another for Psychology. A third consumer is at UW-Whitewater pursuing a degree in education. The final consumer at UW-Whitewater is attending for political science. One consumer took Adult Basic Education classes at MATC. One consumer attended a Criminal Justice Program at WTCT. One attended Herzing College, pursuing a degree in computer networking. The final consumer receiving educational support at the CSP is working on an online program to be a veterinary assistant. Depending on what the person wanted and needed, CSP staff helped people register for classes, coordinate services with the student disability services, obtain financial aid, manage their symptoms while in classes and provide transportation to school.

Another of our success stories this years includes a consumer that had begun working part time several years ago, learned to better manage episodes of increased symptoms while working and has now gained full time employment. This individual has been able to go off Social Security Disability benefits and become financially independent.

In summary, CSP consumers have achieved their employment goals by following the evidence-based model of supportive employment for people who have a severe mental illness. The percentage of CSP consumers working in the community at their goal jobs exceeds the nationally reported average.

Goal number four: Support our Consumer Council and their self identified goals.

The consumer council continued to remain active throughout 2008. One staff member continues to serve in an advisory role at most meetings. The council again elected a slate of officers. The group sponsored activities most months of the year. These included social functions such as holiday parties, a dance, trips to the zoo and a Brewer's game, and picnics at Bartel's Beach and Aztalan Park. They engaged in fundraising activities including a baked potato sale, brat sale, and bake sale at Human Services. They also sent people to participate in a variety of educational and advocacy opportunities including the NAMI and Grassroots Empowerment Conferences. The president and secretary of the council participated in a meeting of other consumer councils in the state to share and develop new ideas to implement. Finally, the council serves as a link between consumer needs and staff services. They council again has set an ambitious schedule for next year, with a goal to implement more fundraising ideas.

Goal number five: Encompassed advancing our implementation of the evidence based practices and monitoring our fidelity to them. We completed fidelity scales for each of the evidence practices for 2008. A fidelity scale indicates how accurately you adhere to the true model. We did not complete consumer interviews in doing these fidelity scales. We will address that in 2009. We did review charts, discussed with the person providing services, the program supervisor, and division manager.

2008 Evidence Based Practices Summary

We completed fidelity scales for each of the evidence practices for 2008. A fidelity scale indicates how accurately you adhere to the true model. We did not complete consumer interviews in doing these fidelity scales. We will address that in 2009. We did review charts, discussed with the person providing the treatment and with the program supervisor.

A. ACT Fidelity score: 118

Our CSP team continues to function as an ACT team. We rated 2 in two areas. One area we rated low in was our nursing hours. We only have eight hours with over one hundred consumers at this time. There are no plans to address this currently. The second area involves the number of consumers we have attending monthly treatment groups for dual diagnosis. We will be offering additional evidence based practice groups for dual diagnosis issues in 2009. We were able to improve one two that we had last year to a 4 with the CSP supervisor providing more direct services to consumers in 2008.

B. Illness Management and Recovery. Fidelity score: 60

We offered this as a group for the past two years. The group was facilitated by a peer support specialist and a clinician. The group has not currently ended but five members are regularly participating. Next year's report will reflect pre and post data for these individuals. For 2009, we would again like to offer the group as well as offering it more for individuals in sessions with his or her case manager for those that are uncomfortable in a group format.

A DBT group was offered beginning in August 2008 and continuing into 2009. This teaches consumers skills in Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and Distress Tolerance. Pre and post data from the functional screens will be reviewed for 2009.

C. Family Psychoeducation

We attempted to conduct a family psychoeducation group at several points in 2008. We were not able to get enough appropriate referrals to run a group. In many cases, it is difficult for an individual interested in the group to find a natural support willing to make the commitment for the group. In 2009, we will attempt to offer the group later in the day and work with consumer's in identifying and recruiting a support to attend the group with them. We will offer it to the entire agency.

D. Integrated Dual Diagnosis Fidelity score: 59

In 2008 a relapse prevention group was offered. We continued to use motivational interviewing and approached treatment in stage-wise interventions. We work as a multidisciplinary approach with time-unlimited services. We offer pharmacological treatments and promote health and wellness. We continue to be low in the percentage of people with co-occurring disorders who participate in both treatment and self-help groups. In 2009, we will work on additional motivational interviewing techniques to encourage people to participate in the array of groups that we offered.

E. Supported Employment Fidelity score: 72

Our CSP and CCS team has one employment specialist, who is fully integrated into the mental health treatment of consumers. The employment specialist does have small caseload size, and is a generalist, completing all phases of vocational services. Employment searches occur in an individualized manner with a permanent, competitive job being the goal. Some people have to wait for services because of delays with DVR, but a rapid job search is attempted. Supports follow the person and occur in the community. We were able to increase the amount of time that our vocational specialist spends providing only vocational supports since September when an individual was reassigned. This person no longer has a case management caseload.

Goal number six: Involved meeting all objectives of our Quality improvement grant and using our data gathered from cost analysis to choose, plan, and implement QI projects.

The quality improvement project stemmed from staff stress levels. A stress scale was implemented resulting in data that many of the CSP workers were experiencing high levels of stress in their lives at the time. Heartmath techniques were introduced to reduce stress and create better health. They have been found that bringing the body into coherence creates a favorable state of neural, hormonal, and biochemical events that benefit the entire body. Heartmath is a technique that involves attempting to breath through the heart while attempting to channel a positive emotion. Staff were instructed in the technique and practiced in team meetings. A computer program was utilized to better instruct individuals when they were in coherence. Stress levels did appear to be reduced over the course of the year. It was also felt that discussing stressors led to positive changes as well. In 2009, staff will begin instructing consumers in the Heartmath techniques.

Goal number seven: Encouraged working toward all consumers having a completed WRAP plan.

A Wellness Recovery Action Plan is a series of activities that produces a plan for people to stay well and to implement a chain of interventions when they develop more symptoms or experience more distressing events. It culminates in a crisis plan that can function as a psychiatric directive. Sixty three percent of consumers currently have completed WRAP plans. We will continue to encourage the process in 2009.

Goals for 2009

1. Train all staff in Trauma Focused Cognitive Behavioral Therapy and begin to implement this with consumers.
2. Update the CSP policy manual.
3. Increase our implementation of evidenced based practices and continue to monitor our fidelity to them throughout the year. Offer a Family Psychoeducation and Integrated Dual Diagnosis Group.
4. Support our consumer council in their self identified goal of running more fund-raisers.
5. Utilize the county web site for training for our new staff member and ongoing training for current staff.
6. Regularly update the mental health database and run quarterly reports to identify problem areas and implement interventions as needed.
7. Continue a Quality Improvement initiative by evaluating data, developing projects, and implementing plans.
8. Create a system to review the quality of documentation at the CSP.
9. Monitor and track staff productivity by reviewing DARS.

Comprehensive Community Services Program (CCS)

~ CCS services reduce the effects of an individual's mental health and/or substance use disorders; assist people in living the best possible life, and help participants on their journey towards recovery ~

The Jefferson County Comprehensive Community Services Program (CCS) completed its second full year. First certified in February 2006, Jefferson County's CCS program was granted a two-year license in March 2007. This license was renewed on February 20, 2009 for two years.

Program Description

CCS is a voluntary, recovery-based program that serves children (0-18), adults (18-62) and senior citizens (63-100) with serious mental health and/or substance abuse disorders. As stated on the State's, Bureau of Mental Health Prevention, Treatment and Recovery website, CCS services reduce the effects of an individual's mental health and/or substance use disorders; assist people in living the best possible life, and help participants on their journey towards recovery.

CCS offer an array of psychosocial rehabilitative services which are tailored to individual consumer. These services include: assessment; recovery planning; service facilitation; communication and interpersonal skill training; community skills development and enhancement; diagnostic evaluations and specialized assessments; employment related skills training; physical health and monitoring; psychoeducation; psychosocial rehabilitative residential supports; psychotherapy; recovery education and illness management; and additional individualized psychosocial rehabilitative services deemed necessary.

General data

During 2008, 61 consumers ranging in age from six to 80 received services. This is an increase of 23 consumers from last year. Throughout 2008, 31 new consumers were admitted and 13 consumers were discharged. Of the consumers admitted to the program, 15 were children and 16 were adults. Of the consumers discharged, 4 were children and 9 were adults. Consumers had diagnoses of: schizophrenia, schizoaffective disorder, bipolar, major depression, borderline personality disorder, post-traumatic stress disorder, various anxiety disorders and substance use disorders.

The CCS staff consists of a Division Manager for Mental Health, a Psychiatrist/Medical Director and a CCS Service Director. There are currently four CCS Service Facilitators, one of whom began in June of 2008. The Alternate Care Coordinator became a part time job developer for CCS in September of 2008. One of our goals has been to maintain staff within the program so we can create a stable program offering consistent services to people. We have been accomplishing this as the program has one full time service facilitator that was hired in 2006 and two more that were hired in 2007. The CCS Service Director has been with the program since 2006.

Consumer Satisfaction

The CCS program conducted a Recovery Oriented System Indicators (ROSI) consumer survey to measure the consumer satisfaction of our program and how recovery oriented we are. We had18 adult respondents this year compared to only 13 last year. Below is the means and percentages table which breaks the survey down into the following categories: overall mean, person centered, barriers, empowerment, employment, staff approach, and basic needs. The barriers and staff approach categories are negatively phrased and a lower

number in these areas shows the program and staff are doing well in these areas. The mean for both of these was 2.0 or below which is what we would like to see. The highest scoring area was in staff approach which consumers rated that 94.1% feel that they had a mostly recovery oriented experience. Another area worth noting is the overall mean, which measures the overall recovery oriented experience, of the ROSI. For 2008 it was 82.4% compared to the overall mean of 58.3% for 2007.

The two areas we targeted from last years ROSI were employment and basic needs. In the employment section we really started to focus on supported employment in September 2008 when we trained the part time job developer. This has been helpful in developing positions in the community and working with consumers in CCS. Consumers respond well and enjoy working with this person. ROSI data shows 53.8% reporting that they had a mostly recovery oriented experience compared to 45.5% in 2007. Since September 2008 we have referred 8 consumers for supported employment. Four of them were just referred in January 2009. Of the 8 people four obtained employment and two have maintained employment. Presently there are 14 individuals who are currently employed and 6 who are seeking employment at this time. There are also 4 people who are pursuing higher education to help them find employment in their area of interest.

The second area, basic needs, is difficult for our program to improve upon as there are two questions in this category which address; 1. Do they have enough money to live on? 2. Do they have affordable housing? We continue to do our best to connect people to services which can be of some assistance to them.

Means and Percentages for ROSI Consumer Survey Scales

	ROSI overall mean	Scale 1 person centered	Scale 2 Barriers	Scale 3 Empowerment	Scale 4 Employment	Scale 5 staff approach	Scale 6 Basic needs
Average for all consumers	3.3	3.6	1.8	3.4	2.8	1.3	2.7
% with mostly recovery oriented experience	82.4%	82.4%	41.2%	88.2%	53.8%	94.1%	46.7%
% with mixed experience	17.6%	17.6%	47.1%	11.8%	23.1%	0.0%	40.0%
% with less recovery oriented exp	0.0%	0.0%	11.8%	0.0%	23.1%	5.9%	13.3%

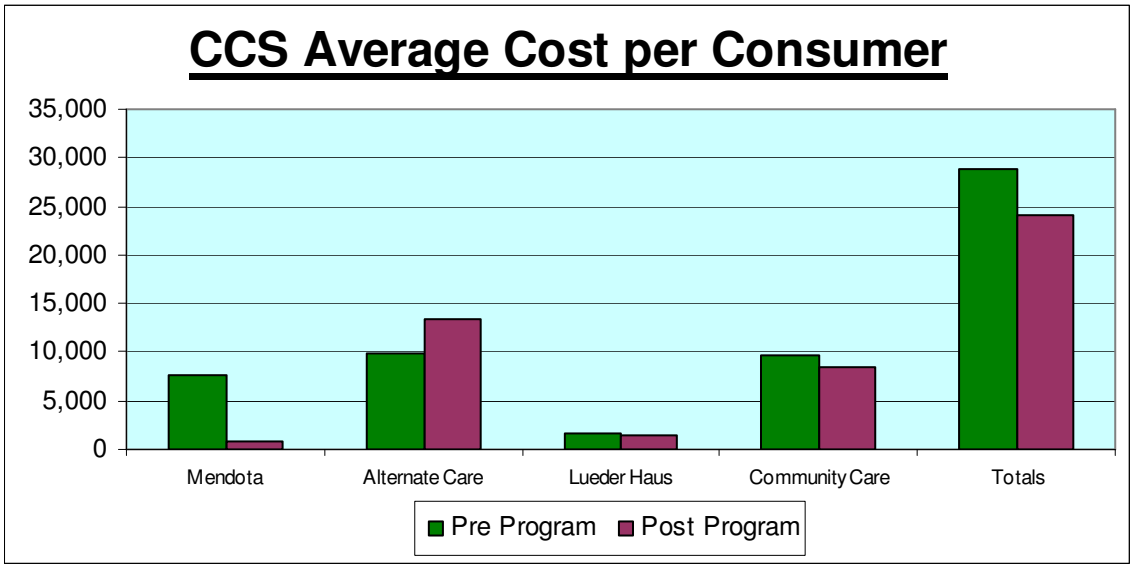
Monetary benefits

In 2008, Jefferson County's CCS program continued billing Medicaid for an array of psychosocial rehabilitative services. For 2008 the program billed $445,903.45 and to this date was reimbursed $300,627.88. In August, Medicaid changed the billing and reimbursement process. As a result, we have yet to receive all the payments from Medicaid for 2008. There are a higher number of people who have a Medicaid deductible, which needs to be met every 6 months before their Medicaid will pay for CCS services. Additionally, there have been people who have lost their Medicaid while in the CCS program. An example of this is a single mother who received Medicaid through her child. The child was placed in foster care and because the child was not living with her she was no longer eligible to receive Medicaid benefits.

In 2007, the CCS program billed $298,671.81 and recouped a total of $328,209.21. A portion of the total received from Medicaid was money Medicaid had not yet paid for CCS services rendered the previous year. In 2006, CCS billed Medicaid $146,259.09 and recouped $131,927.47. Our billing continues to increase each year as we continue to be able to admit more consumers to the CCS program. The dramatic increase in billing

between 2007 and 2008 was due to the fact that we were able to increase the number of full time service facilitators and thereby increase the number of consumers in the program.

A pre/post program analysis was done on the costs of services for the individuals in the CCS program. This showed a savings of 254,937.00 of total costs after coming into the CCS program. The average net costs of saving per enrollee per year in the CCS program total $4,843. This compares to 2007, where the savings was $189,827.00 in regards to pre and post CCS costs. We were able to admit more people which resulted in increased savings.



Children

In 2008, the CCS program served 20 children, ages 6 to 17; of these children, 13 were males and 7 were females. Fifteen of the children resided at home, three lived in treatment foster care, and one child went from treatment foster care to home. One child is currently placed at a residential facility temporarily and is on a waiting list to move to a group home. One child has a mental health commitment order. One young adult is employed.

In 2008, 15 children were admitted to CCS and 4 were discharged. Of the four discharged, one did not meet criteria for the program after further assessment, two chose to withdraw from the program, and one child did not participate for more than 3 months and was discharged.
Of the 20 children that CCS served throughout 2008, 4 of them were admitted for psychiatric hospitalizations. Two of the four were admitted voluntarily to the hospital for a total of 12 days. The other two children were returned, on a total of 4 occasions, either to Winnebago Mental Health Institute or Mendota Mental Health Institute for a total of 192 days.

Adults

In 2008, the CCS program provided services for 38 adults aged 18-60. Of these adults, 10 were males and 28 were females. Nine adults resided at an adult family home, 26 lived in their own home/apartment, and three people lived in supported apartments. The three that currently live in supported apartments had been in Adult Family Homes. A total of 5 people moved out of placement into their own apartments. Two adults had a

guardianship and mental health commitment order and 9 adults had only mental health commitment orders. Four of the nine adults were able to end their mental health commitment order due to recovery.

In 2008, sixteen adults were admitted to CCS and eight were discharged. Two consumers were transferred to a more-intensive program, (CSP) due to increased symptomology and the need for additional services. Five consumers felt that they did not need the supports of the program any longer and they had met the individual criteria for discharge from the program. One consumer passed away.

Between the 17 adults: 146 hospital, 97 Mendota/Winnebago/IMD and 362 Lueder Haus/crisis stabilization bed days were used. In 2007, between 16 adults: 310 hospital days, 73 Mendota/Winnebago/IMD, and 346 Lueder Haus days were utilized. There was a decrease in hospital days from the previous year and an increase in the use of crisis stabilization bed days. The new EMH certification enabled us to use crisis stabilization beds in the community. This allowed people to continue: to receive services; and to attend work or school. This helps people recover more quickly and stay more independent.

Elderly

In 2007, the CCS program served three senior citizens between the ages of 64-80; one was male and two were females. Two lived in their own home/apartment and one resided in an adult family home. One of the seniors was discharged during 2008. There were no hospital days for this group. One of the seniors utilized the Lueder Haus stabilization services for a total of 147 days.

Recovery Plans

Consumer recovery plans are reviewed every six months. Twenty-six consumers participated in the CCS program long enough to have two plans in 2008. Overall, 63% of their goals were met. Seven consumers were able to meet 100% of their goals in 2008. The children met 63% of their goals. The adults met 58% of their goals. The seniors met 95% of their goals. We continued to use person centered planning when doing recovery plans. This approach to conducting the meeting and writing the plans has had a positive response from consumers, family members, contracted providers, and natural supports. Consumers have reported feeling in charge of their services and being able to direct the team in their needs. Family members and providers feel that they can easily read and understand the plan. Family members and other natural supports feel more connected as they are written into the plan providing services to the person. The plans also inform the consumer of the services they are to receive. This increases accountability since everyone on the team knows his or her responsibility in assisting the consumer in building recovery.

Additional service providers

In 2008, the CCS program contracted with seventeen providers.

- Six residential providers, who coached and taught consumers the skills needed to move into their own home or apartment in the future.

- Six agencies provided contracted therapy services. These agencies provided a mix of in-home and agency individual and/or family therapy.

- CCS had 1 contracted mentor. The mentor served as extra support for children and was especially helpful to children in foster care.

- Three peer support specialists assisted the CCS program last year. These trained peers provided support and advocacy for persons in their journey of recovery.

- Three individuals were contracted to provide therapy/service facilitation services.

As residential providers, therapists, mentors and peer support specialists employ psychosocial rehabilitation practices; their services were billable to Medical Assistance through the CCS program.

2008 Trainings

Last year the CCS Program was able to provide 6 trainings to providers and families. They were: CCS 101/Medicaid documentation training, Suicide Assessment and Risk by David Mays, Crisis Response Planning Training by Dan Naylor, Evidenced Based Practices for Adolescents: Trauma Focused Cognitive Behavioral Therapy and COPING CAT presented by Kathi Cauley, Illness Management and Recovery, an evidenced based practice, presented by Kim Propp and Marj Thorman, and Residential support benefit and documentation presented by Kim Propp and Brian Weber. We continued to do outreach to the school districts, in particular Watertown and Jefferson. We hope to continue to develop a strong partnership with the schools to help them understand and support children and adolescents diagnosed with a metal illness.

2008 Evidenced Base Practices

CCS worked in partnership with the CSP to offer the following evidenced based practice groups; Illness Management and Recovery, Supported Employment, and Integrated Dual Diagnosis. The Seeking Safety group was offered to adolescents, women, and men. The women's group was facilitated by a CCS service facilitator and a female peer support specialist. The men's group was facilitated by a CCS service facilitator and male peer support specialist.

As of December 2008, 25 CCS consumers have completed the Wellness Recovery Action Plan (WRAP). There are WRAP plans for adults and children. The plans assist consumers in recognizing symptoms and triggers, creating plans, and directing providers and support people as to what they need in time of crisis.

Fidelity scales were completed for each of the evidence practices for 2008. A fidelity scale indicates how accurately you adhere to the true model. Consumer interviews were not conducted in completing these scales and that will be addressed in 2009. We did review charts, discussed with the person providing the treatment and with the program supervisor and division manager.

- Illness Management and Recovery. Fidelity score: 60
  CSP offered this as a group for the past two years and currently is conducting this group. CCS service facilitator and a peer support specialist have started a group for 2009. Currently there are 3 consumers attending this group from CCS. Next year's report will reflect pre and post data for these individuals. We continue to offer the material on an individual basis for those who are not comfortable with the group format.

- A woman's seeking safety group was started in September 2008. We currently have 7 women from CCS involved in this group. This is an integrative treatment approach for PTSD and substance abuse. This group provides tools and techniques to teach "safe coping skills".

- A DBT group was offered beginning in August 2008 and continuing into 2009. CCS has 2 women involved in the DBT group. This teaches consumers skills in Mindfulness, Interpersonal Effectiveness,

Emotion Regulation, and Distress Tolerance. Pre and post data from the functional screens will be reviewed for 2009.

- A family psycho education group was attempted at several points in 2008. We were not able to get enough appropriate referrals to run a group. In many cases, it is difficult for an individual interested in the group to find a natural support willing to make the commitment for the group. In 2009, we will attempt to offer the group later in the day and work with consumer's in identifying and recruiting a support to attend the group with them. We will offer it to the entire agency.

- Integrated Dual Diagnosis Fidelity score: 59
  In 2008 a relapse prevention group was offered. We continued to use motivational interviewing and approached treatment in stage-wise interventions. We work as a multidisciplinary approach with time-unlimited services. We offer pharmacological treatments and promote health and wellness. We continue to be low in the percentage of people with co-occurring disorders who participate in both treatment and self-help groups. In 2009, we will work on additional motivational interviewing techniques to encourage people to participate in the array of groups that we offered.

- Supported Employment Fidelity score: 72
  Our CSP and CCS team has one employment specialist, who is fully integrated into the mental health treatment of consumers. The employment specialist does have small caseload size, and is a generalist, completing all phases of vocational services. Employment searches occur in an individualized manner with a permanent, competitive job being the goal. Some people have to wait for services because of delays with DVR, but a rapid job search is attempted. Supports follow the person and occur in the community. We were able to increase the amount of time that our vocational specialist spends providing only vocational supports since September when an individual was reassigned. This person no longer has a case management caseload. There are 8 consumers from CCS served in supported employment at this time.

CCS Coordinating Committee

The CCS Coordinating Committee is currently comprised of consumers, staff, and community members. The committee meets every other month for one hour. The meetings are held at Horizons drop in center in Fort Atkinson. Elections were just completed for the board positions for the next two years. The officers are; President – Heidi Knoble, Vice President – Kathy Cordio, Secretary – Katie Pytier, and Treasurer – Ryan Miller.
The CCS Coordinating Committee is submitting the following recommendations for the CCS program in 2009.

- Learn and implement Coping Cat and Trauma Focused CBT for children. Coordinate workgroups and supervision for providers who are interested in using this evidenced based practice.
- Facilitate guided reflections training session led by Dianne Greenly and Molly Cisco.
- Purchase the Incredible Years material and partner with a school to implement the curriculum among teachers, providers, and parents.
- Facilitate an outing to Horizons drop in center to get consumers connected with this new resource.
- Hold a group at Horizons drop in center.
- Continue to communicate with school districts and meet with them to educate them on children's mental health and what services the CCS program can provide.
- Coordinate training for parents and foster parents led by Joann Stephens.

Review of 2008 Program Goals

- **Learn and implement at least one evidenced based practice for children.** We were able to do training on coping cat and trauma focused cognitive behavioral therapy. We will be starting our workgroups this year to implement these therapies.

- **Facilitate six to eight trainings for providers and families with three of them being focused on children's mental health and recovery.** We were able to accomplish this goal and provide six training to providers and consumers. We had three trainings specific to children. The training on crisis response planning, Coping Cat and Trauma Focused CBT, and Alice Mirk's training on the children's functional screen.

- **Set up a meeting with Alice Mirk to come and talk with the Children's teams at the agency and answer questions regarding the children's mental health screen.** Alice was able to meet with us in early 2008 to discuss the children's screen and answer questions from the various teams that work with children. We were able to discuss eligibility for children to be in CCS and everyone was able to come away with a better understanding of the screen and the criteria that needs to be met for a child to be eligible for the CCS program.

- **Have at least one training on attachment issues with children. Find a therapist and other supports for families regarding attachment.** We have found a couple of therapists who work with children with attachment issues but were not able to coordinate a training this year that dealt with this issue.

- **Continue to communicate with School districts and meet with them to educate them on children's mental health and what services the CCS Program can provide.** This year we were able to do more outreach with Jefferson, Johnson Creek, and Watertown schools. We were able to build collaborative relationships with schools in these districts which have been very helpful. Previous years we have done outreach with Fort Atkinson and Lake Mills schools. CCS Service Director was also able to attend a meeting with the School superintendents from Jefferson County to hand out materials and talk about the CCS program.

- **Continue to meet the quality improvement grant goals.** One of the goals that we worked on was the implementation of Heart Math to reduce the stress levels of staff. The feedback from staff was positive and we were able to teach consumers how to utilize this tool also. We worked with teens to use this technique to decrease their anxiety and stress and to do better in school. We had 4 teens start this and two who are continuing it. We are using the Spence anxiety scale to track progress. We also focused on supported employment as mentioned prior. Our ROSI data showed improvement was needed in that area and currently 11 people are employed, 6 people want employment, 2 people are in some type of higher education, and 2 more people are applying for school.

- **Offer a seeking safety group for men co-facilitated with a male peer support specialist.** This group was offered but due to persons leaving the group because of work, school, or moving the group ended early. We will try to facilitate another group in 2009.

- **Offer a seeking safety group for women co-facilitated with a female peer support specialist.** This group is currently still running and has had a strong base of interest. They have really maintained participation in this group and those that attend report positive outcomes from it.

- **Offer a seeking safety group for adolescents.** This group was started for female adolescents and the participation tapered off and the women's group was then formed.

Goals for 2009

1. Update the CCS policy manual

2. Increase the implementation of evidenced based practices and continue to monitor our fidelity to them throughout the year.
3. Continue to utilize the county website for training of staff, consumers, and contracted providers.

4. Create a quality improvement team of staff and consumers to evaluate data, develop projects out of the data, and come up with implementation plans.

5. Clarify through the state data base portal which consumers are in CCS when updating the Mental Health AODA functional screens. This will help us get data for quality improvement projects and to track how the program is doing.

6. Implement a quality improvement cost looking at why the alternate care costs have increased and how to effectively decrease those costs.

7. Implement Functional Family Therapy with children 11-18 years of age and their families. This is evidenced based and is proven to keep children out of residential placements and detention facilities and in the home.

8. Implement Coping Cat and Trauma Focused CBT workgroups to start providing these therapies to CCS consumers.

9. Provide trainings to foster homes, treatment foster homes, and group homes for children in regards to the CCS program and the residential support benefit. This will assist us in recouping money for children who are placed out of the home. The skills that the providers will teach the children will help them to enter back into the home sooner.

Training Goals for 2009

- Expand on Supported Employment; we are working at raising our fidelity to the model. At one time there was a high fidelity and then the supported employment specialist needed to take on a caseload and the fidelity went down. As of September 2008 we have someone doing job development and have been successful thus far. There have been 8 total CCS consumers referred to the job developer to date. Of the 8 people, 4 have been hired at jobs and 2 have remained in employment. One individual had a job opportunity but turned it down as she did not want the hours that were offered.

- March 6, 2009 we will be conducting training for supported employment.

- March 2, 2009 Dianne Greenley will be coming to do some strategic planning for our CCS. She will be meeting with staff and consumers to discuss how to improve things and build upon the strengths the program has. Depending on what comes out of the strategic planning we will look at trainings to assist us in strengthening our program and provided services that meet consumer's needs.

- Joanne Stephens will be coming May 16, 2009 to do training for parents and support people as to how to navigate systems. CCS is teaming with Wraparound to host this training.

- Workgroups will be started on April 13, 2009 for Trauma Focused – CBT and COPING CAT, both evidenced based practices for Children and Adolescents. We conducted a day training last year and will be following up with workgroups so we can properly implement these into our program.

- We are also forming a subcommittee of our CCS Coordinating Committee to look at improving services in one of our stabilization bed facilities. A listening session was conducted last year and we will work with the results of that to implement changes. The committee, largely based of consumers, will review policies, house rules, and services offered.
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Emergency Mental Health

~ Individuals receive crisis assessments, response planning, linkage and follow up, and crisis stabilization services.~

Our Emergency Mental Health (EMH) crisis intervention services were certified under HFS 34 in October of 2007. In May of 2008, as part of the outpatient mental clinic certification, we received certification for two more years. In becoming certified, the Department did not have to add any new services or new staff. We had to conceptualize what we were doing in terms of crisis intervention services into Emergency Mental Health services and then amend our practice and service delivery system. The Department did have to organize procedures, formalize policies, develop billing systems and train staff across the entire agency.

In 2008 we began training staff in EMH procedures and skills. George Hullick from the State of Wisconsin, Department of Health Services and the Bureau of Prevention, Treatment, and Recovery presented on HFS 34. Dr. David Mays gave a full day training on Suicide Assessment. Kathi Cauley conducted six one day trainings on Emergency Mental Health procedures, systems, and services. Dan Naylor presented a half day training on crisis and response plans. Over 70 staff attended these trainings.

EMH procedures and policies were reviewed by nearly all staff in the Behavioral Health and Child and Family Division. Almost all staff in both of these divisions completed the required orientation and training to deliver EMH services and to bill Medicaid for these services.

Over 450 people received Emergency Mental Health services in 2008. These people received crisis assessments, response planning, linkage and follow up, and crisis stabilization services. Of the crisis assessments completed, 323 were in response to suicide calls. Two hundred nine of these callers were able to be assisted in the community with services from our clinic staff, which include psychiatry, medication, and counseling, and with support from friends and family. The remaining suicide calls resulted in 114 emergency detentions. This is a very impressive number of people who are suicidal being diverted away from an acute setting state hospital. This occurs because Human Service intake workers complete a Crisis Assessment and make the decision about the need for an emergency detention. It works because we have mental health professionals and a psychiatrist who are able to see people with acute symptoms on the same day and then follow them closely. This system, which we have used for over ten years, is being replicated across the state. The Governor's proposed biennium budget contains language encouraging counties and law enforcement to develop such a procedure.

In the first year of certified Emergency Mental Health services, we billed $141,967. We received payment for $60,505. This is for services we were previously providing and as such is a new source of revenue. This number is expected to grow in 2009.

Additional data collected for 2008 reflect that there were 994 Emergency Mental Health contacts. This means that there were 994 separate incidents with the people who received EMH services. Eighty four people were served by the Lueder Haus, our crisis stabilization facility.

Consumer Satisfaction

In December of 2008, we held a listening session with consumers who had stayed at our Lueder Haus. This focus group session was conducted by Molly Cisco, the executive director of Grassroots Empowerment Project. The consumers who attended expressed an interest in having group counseling for anxiety and relaxation; more skill training, especially in relation to preparing meals; more input into the programming that goes on; and more positive messages from the staff. A Lueder Haus Consumer Council will be developed to address these concerns. The Council will review all rules and programs of the Lueder Haus. A Wellness Recovery Action Plan (WRAP) group will start at the Lueder Haus in March and be offered throughout the year. An Anxiety Reduction Group will also be offered this spring at the Lueder Haus. Additionally, all staff of the Lueder Haus will be trained in trauma informed care and asked to review the trainings on our training website during 2009.

Goals for 2009

The following goals have been set for 2009:

1. Each division of the agency will adhere to their quality assurance procedures. This involves matching the billing with the documentation and reviewing documentation for quality.

2. We will develop at least two providers for crisis stabilization beds for children.

3. The Lueder Haus Consumer Council will be formed. This Council will be asked to review the rules and procedures of the Lueder Haus and make suggestions to improve the ongoing programming.

4. We will review and stream line all of our EMH forms.

5. We will review and stream line all of our EMH procedures and systems across the agency, including the billing and secretarial systems and staff.

6. We will improve our data tracking by insisting on consistency in our coding and defining what diversion from emergency detention means for all staff.

7. We will participate in the regional Emergency Mental Health grant for training resources and money.

8. The Lueder Haus staff will receive additional training and all staff will be trained in trauma informed care.

DEVELOPMENTAL DISABILITIES

~ The Developmentally Disabled, Elderly and Physically Disabled have been transferred into Family Care. ~

Readers will recall that Jefferson County has been planning to enter Family Care for the past two years. As of February 2009, our consumer groups, including the Developmentally Disabled, Elderly and Physically Disabled, have been transferred into Family Care.

Family Care is the State operated care management plan for qualified Medicaid consumers that replaces the county operated Community Options and Community Based Waiver programs. Under the State approved Family Care plan for Jefferson County, a private, non-profit organization known as Care Wisconsin is now programmatically and financially responsible for community based care and service delivery for our developmentally disabled consumers. In order to maintain continuity of care for our consumers and provide Care Wisconsin with quality social work staff, thirteen Jefferson County case managers have been sub-contracted to Care Wisconsin to continue to provide services though the Family Care Program. Most of these case managers have years of experience working with the developmentally disabled, longstanding relationships with our consumers, and strong community knowledge and ties. They will continue to be vital assets for our consumers and Care Wisconsin.

The process of transferring our consumers to Family Care started in September of 2008 with an individualized plan for each person that included file transfer, and meeting with each consumer, and/or guardian, to discuss and plan for options available through Family Care. Also at this time our Jefferson County sub-contracted case managers moved to the new Care Wisconsin office in Jefferson. These staff then began to learn the Family Care Program guidelines, processes, procedures and forms that go with the new program. In total, 573 developmentally disabled consumers were transferred from the Waiver programs to Family Care between Sept 1st 2008 and Feb. 1st 2009. For persons interested in the specific program transfers, this number represents the following numbers of consumers; 402 CIP IB, 13 IA, 10 Brain Injured, and 148 elderly or physically disabled. During the same time frame, additional consumers were taken off the county's wait list, at the rate of two per month, and more were relocated from the Developmental Disability Nursing Home sections of Bethesda Lutheran Home in Watertown and St. Coletta Alverno in Jefferson.

Jefferson County maintains some responsibilities for developmentally disabled consumers including court services related to guardianships, protective placements, the annual reviews of these, known as WATTS reviews, and mental health services, including any legal commitments for treatment that may be needed. Additionally, a small number of consumers who are not eligible for Family Care, continue to receive county services including care management, protective payee, and community outreach. Human Services continues to be responsible for providing protective services for the developmentally disabled, which includes investigating allegations or reports of physical, financial, or emotional harm and taking appropriate protective or legal actions.

All in all, the past year has been one of tremendous change in our Long Term Support areas. Readers are encouraged to learn more by reading the section on our new Aging and Disability Resource Center and related section on Aging Services.

EARLY INTERVENTION

~ Early intervention works in partnership with the family to enhance their child's development and support the family's knowledge, skills and abilities as they interact with and raise their child. ~

The Jefferson County Early Intervention Program, established in 1979, has a strong commitment to working with families and staff as a team to provide the best-individualized program for each child.

The Mission of the Program states that they are committed to children under the age of three with developmental delays and disabilities and their families. They value the family's primary relationship with their child.

They work in partnership with the family to enhance their child's development and support the family's knowledge, skills and abilities as they interact with and raise their child.

The Program staff consists of speech and language pathologists, physical therapists, occupational therapists, service coordinators, educational specialists, and a director. Consultations are done with many other specialists to meet the needs of our families.

A child qualifies for services one of three ways. The first and most common way is by a 25% delay in one area based on a normative test. The second way is a diagnosis from a physician. The third way is atypical development as determined by a professional.

GUIDING PRINCIPLES

The following guiding principles direct our planning and program decisions. As the early intervention system grows and develops, its success should be measured by the success with which we are able to realize these principles. The following is a summary of those principles.

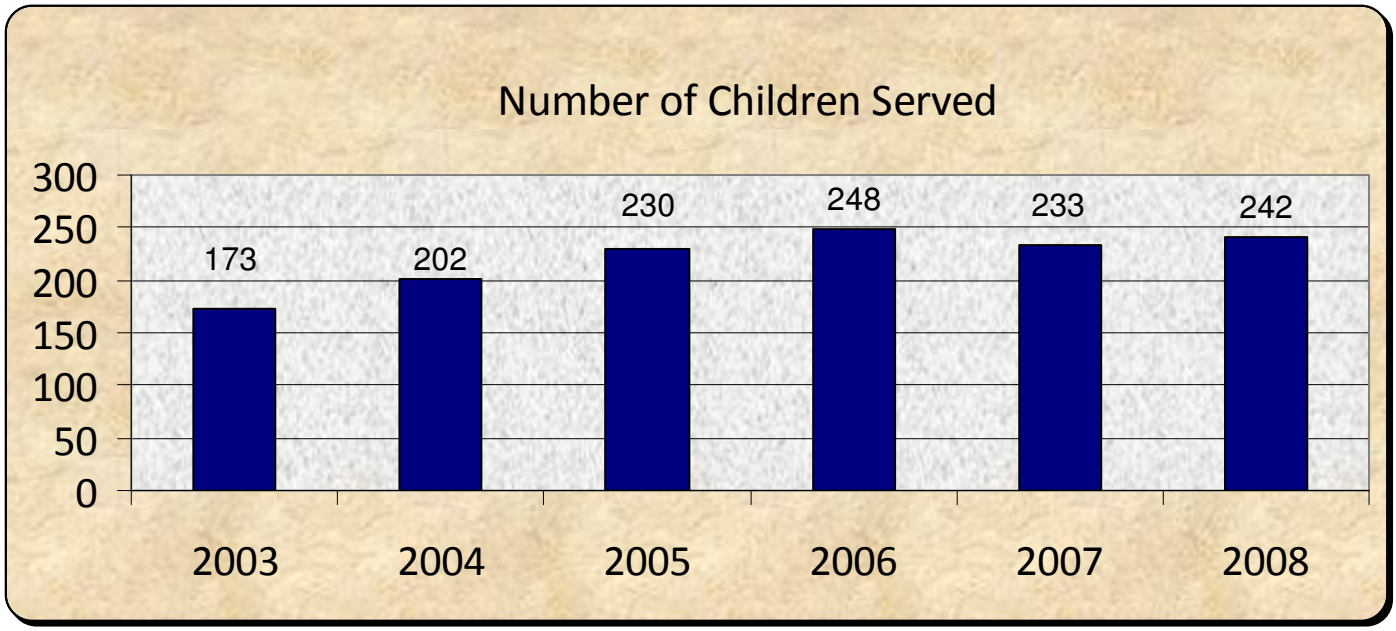
- Children's optimal development depends on their being viewed first as children, and second as children with a delay or disability.
- Children's greatest resource is their family. Children are best served within the context of the family. Young children's needs are closely tied to the needs of their family.
- Parents are partners in any activity that serves their children. Parents or primary caregivers have a unique understanding of their children's needs.
- Just as children are best supported within the context of family, the family is best supported within the context of the community.

- Professionals are most effective when they work as a team member with parents and others.
- Collaboration is the best way to provide comprehensive services. No single agency is able to provide all services to all children and families.
- Early intervention enhances the development of children. Early intervention is appropriate for children and families.

After the age of three, a child's education does not end. It is our role to work with the family to find the best "next step" for the child. At 27 months of age, the discussion of transition begins. A service coordinator will discuss the options. A transition meeting will be held with preschools, HeadStart, Early Childhood, and/or a private agency to discuss the needs of the child and family. Transition can be both an exciting time and a very nervous time. We encourage families to visit any of the potential programs. A final planning meeting will be held before the child turns three to determine the family's final decision.

The Early Intervention Program is funded through county, state, federal funds, insurance benefits and the Parental Cost Share. In addition, the United Way of Jefferson County and N. Walworth Counties, Watertown United Way, St. Vincent DePaul, community organizations, and private individuals provide generous support to our program.

The chart and graphs below show the enrollment dating back to 2003. It is very important to remember that Early Intervention services <u>are mandated</u> services; therefore, *a program may not have a waiting list*. Every child that qualifies must be served.



	2003	2004	2005	2006	2007	2008
Total Number of Children Served	173	202	230	248	233	242
Number of Referrals	142	156	169	176	144	141
Hispanic Families Served	24	25	40	41	39	18
Black Families Served	0	0	0	5	3	2
Asian Families Served	0	0	3	4	2	2
Pacific Islander Families Served	0	0	0	0	0	1

Summary Of Data

As shown by the above data, the Early Intervention Program has stabilized over the past few years. The Department of Health and Family Services has not changed the qualification criteria; therefore, we hope to remain in this stable position. It is very important to remember that Early Intervention services are mandated services; therefore, *a program may not have a waiting list*. Every child that qualifies must be served.

Busy Bees Preschool

~ Busy Bees Preschool provides a positive learning experience through a fun-filled morning with a structured routine and consistent behavioral limit. ~

The Busy Bees Preschool is a preschool for two and three year old children that opened in September of 2005. It offers two morning sessions; Session One is Mondays and Wednesdays and Session Two is Tuesdays and Thursdays. Both sessions run from 8:30 am to 11:00 am. The preschool runs from September to June for up to 12 children each day. The population is a combination of community members and children with special needs.

The Preschool provides developmentally appropriate activities in a seasonal thematic manner. The content of the day is presented through a consistent routine. The activities emphasize language and concept development through free play, music, finger plays, books, gross and fine motor activities, art experiences, and daily living skills, which will include a snack time and a bathroom routine. These activities address all developmental domains and incorporate quiet and active time. The snack is provided by the preschool and includes at least two food groups based USDA guidelines.

Units are planned in advance so that families receive a unit letter to promote follow through in the home setting. This preparation also ensures smooth transitions and minimal amounts of time that children are waiting. Children are encouraged to express themselves during activities and guided to the next developmental level. Materials will cover diverse themes and cultures. Families are encouraged to share their experiences and cultures in order to educate children about the diversity of our population.

Busy Bees Preschool provides a positive learning experience through a fun-filled morning with a structured routine and consistent behavioral limit. Children will increase their self-esteem and confidence through understanding and succeeding at our preschool. In cases of unwanted behaviors, the staff will redirect and use positive reinforcement to encourage positive interactions. If unwanted behaviors persist, the family and staff will develop a behavioral plan. Negative modification techniques like physical punishment, withholding food or verbal abuse will never be used. The Busy Bees Preschool believes that these activities are unethical and will lessen a child's self-esteem and self-image.

The Preschool has become incredibly popular and has increased its services to offer a summer session for five weeks during July and August. Our first session was in 2007 and families have been reserving a spot in the 2008 session.

AGING & DISABILITY RESOURCE CENTER (ADRC)

~ADRCs are service centers that provide a place for the public to get accurate, unbiased information on all aspects of life related to aging or living with a disability.~

ADRCs are service centers that provide a place for the public to get accurate, unbiased information on all aspects of life related to aging or living with a disability. Individuals, family members, friends or professionals working with issues related to aging, physical disabilities, developmental disabilities, mental health issues, or substance use disorders, can receive information specifically tailored to each person's situation.

ADRCs are also places where people can access Wisconsin's publicly funded long term care programs, including Family Care and Partnership (managed care) and the new Self-Directed Supports Waiver Program called IRIS, *Include, Respect – I Self Direct.*

The Aging & Disability Resource Center of Jefferson County began operations on 7/1/08 Following are statistics covering the first six months of operations:

Information & Assistance: 1,181 contacts were received or made: The majority were from/to Fort Atkinson (318) and Jefferson (220).

- 22% of callers were relatives/guardians/friends or neighbors who were calling on behalf of another;
- 21% of callers were from another agency/service provider; &
- 18% of callers self-initiated the contact.
    - 605 calls were on behalf of people 60+;
    - 484 calls were on behalf of people aged 18-59;
        - 164 with physical disabilities;
        - 142 with developmental disabilities;
        - 72 with mental health/AODA issues;
    - 10 calls were on behalf of individuals aged 17.

- **Medicaid Waiver Program Roll-overs**: 615 individuals were enrolled into publicly funded long term care from the counties Medicaid Waiver Programs:
    - 80% Family Care
    - 15% Partnership
    - 10% IRIS

- **ICF MR Relocations**: Options counseling and enrollment consultations were provided to 17 residents and/or their legal representatives in conjunction with a closing or downsizing agreement between St. Coletta's, Bethesda Lutheran Homes and the Department of Health Services.

- **Long Term Care Functional Screens**: 176 Long Term Care Functional Screens were administered to individuals interested in applying for publicly funded long term care.

- **Community Relocations from Nursing Homes**: Individuals in skilled nursing homes, who are on Medicaid & were admitted for long term care are exempt from waiting list requirements. The ADRC processed 36 relocation requests between 7/1-12/31/08.

- **Waiting List Management:** At the onset of managed care, the waiting list contained 168 names. The county's state approved transition plan allowed for the removal of 7 individuals per month: 4 elderly, 2 persons with developmental disabilities and 1 person with physical disabilities. Additional people were removed when a Family Care/Partnership or IRIS participant vacated an original "slot". Between 7/1-12/31/08 the ADRC provided options counseling and/or enrollment consultations to 71 individuals on the waiting list and 51 were enrolled.

AGING

~ The goal of this unit is to help people remain independent and safe within their own homes and communities by providing them with individualized services to meet their needs.~

Jefferson County Senior Dining Program

Fellowship, Food Fun

In 2008, Jefferson County's Senior Dining Program provided 36,491 hot, noon meals to the elderly and people with disabilities. The congregate sites served 20,515 meals, and 15,976 home deliveries were made. For the fifth year in a row, the program saw an overall decrease in the number of meals served when compared to the previous year, 16% in 2007 and 2% in 2008). The program provided 1,650 home delivered meals to individuals enrolled in the Medicaid Waiver Program, Family Care or Partnership, this resulted in $16,368 in program revenue. In addition to meals, the Senior Dining Program provides participants with nutrition education/counseling and medication management services.

Transportation Services

The s85.21 Specialized Transportation Program provides counties with financial assistance so that they can provide transportation services to the elderly and persons with disabilities on a trip *priority* basis. Priority trips in Jefferson County are for medical and nutritional services; the following projects are partially funded under this grant:

1. Elderly Services Van: Provides transportation on a fixed route basis to elderly and disabled individuals for grocery and other shopping trips. In 2008, 3,043 one-way trips were provided. Passengers are asked for a co-payment of $1.00 per trip.

2. Taxi Program Subsidy: Provides a user-side subsidy for taxi services provided to elderly who use the taxi in order to attend a Senior Dining Program in Fort Atkinson, Jefferson and Lake Mills. In 2008, 1,080 one-way trips were subsidized at .75 per trip.

3. Driver-Escort Program (volunteer drivers)*: Provides door-to-door transportation to elderly and disabled individuals for medical appointments when they have no other means of getting there. In 2008, volunteer drivers provided 4,992 one-way rides. This reflects a 47% increase in rides from 2007. This increase, in conjunction with the exorbitant costs of fuel, led to the program being over budget and 20% in cuts were made in the 2009 budget in order to control costs.

Benefit Specialists

In 2008, the Elderly Benefit Specialist Program served 752 clients with 1366 cases and provided a monetary impact of $1,046,557 in recouped federal/state/other dollars for Jefferson County's elderly residents! These dollars help stimulate our local economy by providing seniors with additional funds to pay for essentials, rent and/or property taxes. As in 2007, approximately half of those cases, 676 (49% of caseload) were Medicare, Medicaid, or other insurance related issues. The additional Part D and Medicare Advantage workload has permanently "upped" the demands for the EBS program, but FoodShare cases also jumped 55% (from 43 cases in 2007 to 67 cases in 2008). In an effort to meet the increased demand for Medicare counseling and all its complexities, the EBS program now offers an "ABCs of Medicare" workshop twice a year for Jefferson County residents who will be newly eligible for Medicare. These workshops are held at the Fort Memorial Hospital and have been very well received by the public.

The Disability Benefit Specialist Program (DBS) is a new program that is funded through the ADRC. The services provided by the DBS mirror those provided by the EBS with a few exceptions. The DBS works with people with disabilities aged 18-59 and spends much of her time working with people who are interested in applying for Medicaid, Social Security Disability or appealing a benefit denial. From 7/1/-12/31/08, the DBS worked on 78 cases. The individuals served identified themselves as having a physical disability (53%); mental health issue (40%) or developmental disability (7%). The monetary impact in terms of benefits for consumers totaled $186,753!

Family Caregiver Support Programs

The department currently coordinates caregiver services and benefits under the following two programs: 1) Family Caregiver Support Program; and 2) Alzheimer's Family Caregiver Support Program. These programs are intended to provide caregivers with information about available services; assistance in gaining access to services; individual counseling, support groups and training; respite care to give them a break from providing care and supplemental services to help provide care.

Elder Abuse & Neglect

97 reports of Elder/Vulnerable Adult Abuse & Neglect were received in 2008. Reports were made on behalf of the following target groups: 81 Elderly, 6 Developmentally Disabled and 6 Physically Disabled. Abuse was reported in the following areas:

- 57 Self Neglect
- 12 Neglect by others
- 14 Financial Abuse
- 6 Emotional Abuse
- 5 Physical Abuse
- 2 Sexual Abuse
- 1 Unreasonable Confinement

Young & Old Stick Together YOST

The YOST program is an intergenerational program that builds "understanding, communication, appreciation and relationships" between high school students and senior citizens. Approximately 50 high school seniors participate in this program on an annual basis and when classes were held in September 2008. This program links the students and seniors together throughout the school year, but rarely does the relationship end after graduations. This program is truly one-of-a-kind in Wisconsin.

FINANCIAL REPORTS

The Financial Reports that follows summarize Department resources and expenditures by source and type, by target group, and by service type. Data are presented in numeric and pie chart formats. Total resources for 2008, including County tax levy, were $35,871,472. Total expenditures were $35,867,865.

2008 RESOURCES & EXPENDITURES

(unaudited)

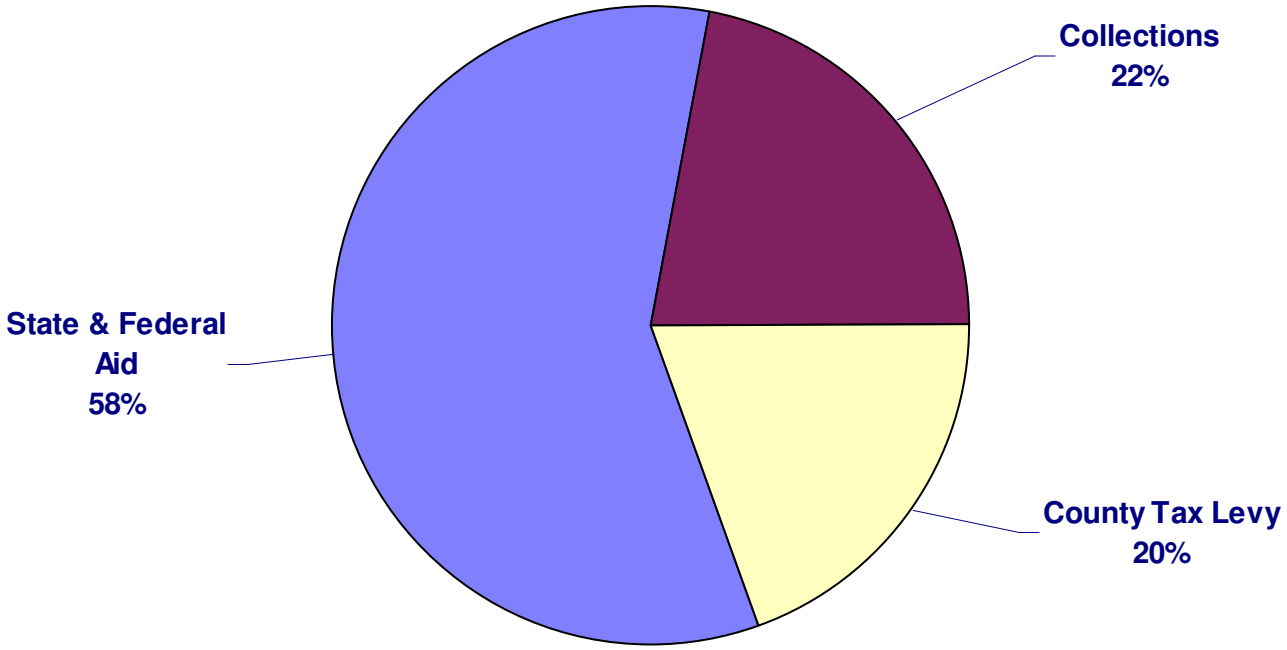
RESOURCES	ACTUAL	BUDGET	VARIANCE
State & Federal Aid	$ 20,994,439	$ 22,478,375	$ (1,483,936)
Collections	7,828,676	7,910,000	(81,324)
County Tax Levy	7,008,501	6,823,824	184,677
Fund Balance Carryover	40,000	40,000	0
Total Resources	**$ 35,871,616**	**$ 37,252,199**	**$ (1,380,583)**

EXPENDITURES	ACTUAL	BUDGET	VARIANCE
Personnel & Operating	$ 12,641,140	$ 12,431,769	$ (209,371)
Client Assistance	340,854	300,309	(40,545)
Medical Assist. Waivers	18,180,237	20,067,400	1,887,163
Community Care	748,594	660,300	(88,294)
Child Alternate Care	1,884,637	1,350,000	(534,637)
Hospitalizations	620,435	621,000	565
Other Contracted	1,451,968	1,821,421	369,453
Total Expenditures	**$ 35,867,865**	**$ 37,252,199**	**$ 1,384,334**

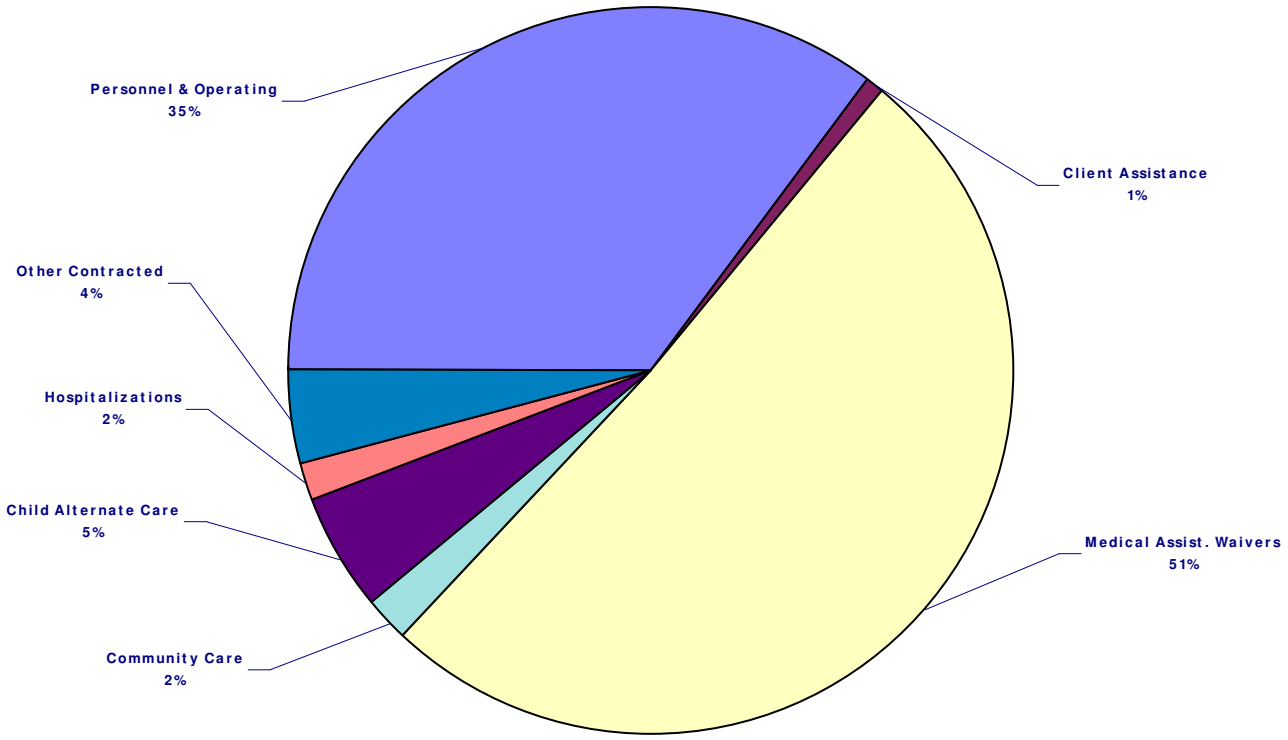
SUMMARY	VARIANCE	PERCENT
Resources	(1,380,583)	-3.7%
Expenditures	1,384,334	3.7%
Net Suplus	**$ 3,751**	**0.0%**

2008 operations resulted in a net surplus of $3,751 (one one-hundredth of one percent of total budget), which was lapsed into the County General Fund.

2008 Resources

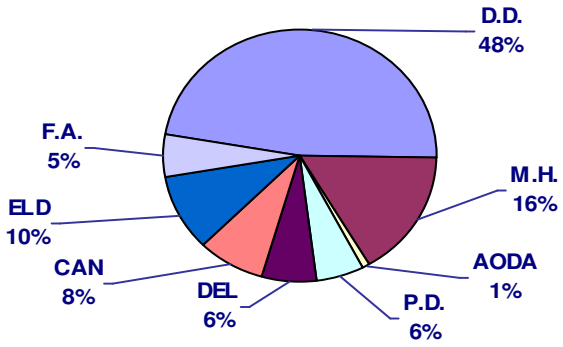


2008 Expenditures

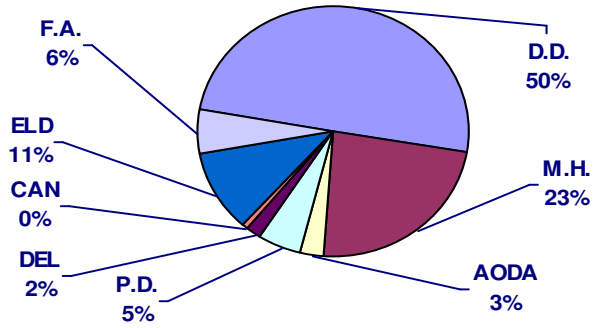


2008 Costs by Target Group

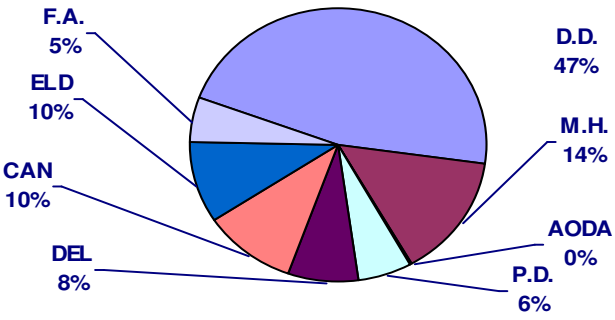
Total Expenditures		
Develop. Disabilities	***D.D.***	17,014,382
Mental Health	***M.H.***	5,854,474
Alcohol & Drug	***AODA***	328,567
Physical Disabilities	***P.D.***	2,013,027
Delinquency	***DEL***	2,289,260
Child Abuse/Neglect	***CAN***	2,901,656
Elderly	***ELD***	3,506,635
Financial Assistance	***F.A.***	1,959,864
TOTAL		35,867,865



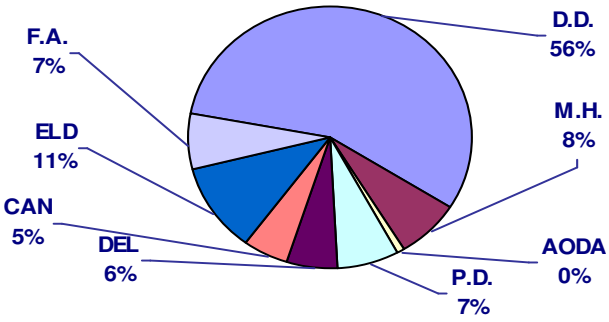
Collections & Donations		
Develop. Disabilities	***D.D.***	3,923,600
Mental Health	***M.H.***	1,814,389
Alcohol & Drug	***AODA***	229,316
Physical Disabilities	***P.D.***	389,405
Delinquency	***DEL***	155,168
Child Abuse/Neglect	***CAN***	25,198
Elderly	***ELD***	840,819
Financial Assistance	***F.A.***	450,781
TOTAL		7,828,676



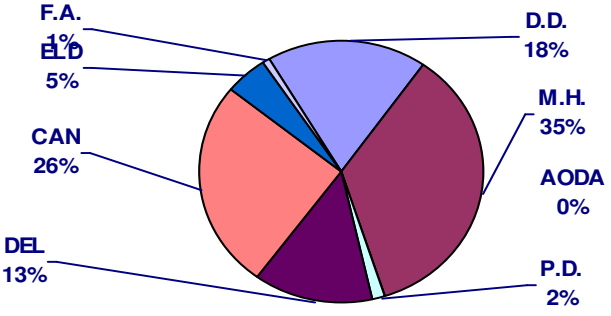
Net Costs		
Develop. Disabilities	***D.D.***	13,090,782
Mental Health	***M.H.***	4,040,085
Alcohol & Drug	***AODA***	99,251
Physical Disabilities	***P.D.***	1,623,622
Delinquency	***DEL***	2,134,092
Child Abuse/Neglect	***CAN***	2,876,458
Elderly	***ELD***	2,665,816
Financial Assistance	***F.A.***	1,509,083
TOTAL		28,039,189



State & Federal Funding		
Develop. Disabilities	***D.D.***	11,793,453
Mental Health	***M.H.***	1,581,680
Alcohol & Drug	***AODA***	99,251
Physical Disabilities	***P.D.***	1,516,105
Delinquency	***DEL***	1,187,165
Child Abuse/Neglect	***CAN***	1,060,560
Elderly	***ELD***	2,320,478
Financial Assistance	***F.A.***	1,435,747
TOTAL		20,994,439

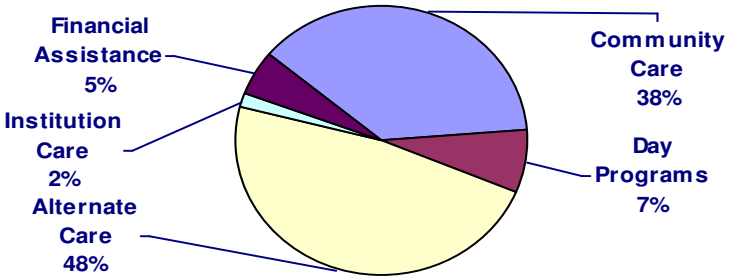


Net County Cost		
Develop. Disabilities	***D.D.***	1,297,329
Mental Health	***M.H.***	2,458,405
Alcohol & Drug	***AODA***	0
Physical Disabilities	***P.D.***	107,517
Delinquency	***DEL***	946,927
Child Abuse/Neglect	***CAN***	1,815,898
Elderly	***ELD***	345,338
Financial Assistance	***F.A.***	73,336
TOTAL		7,044,750

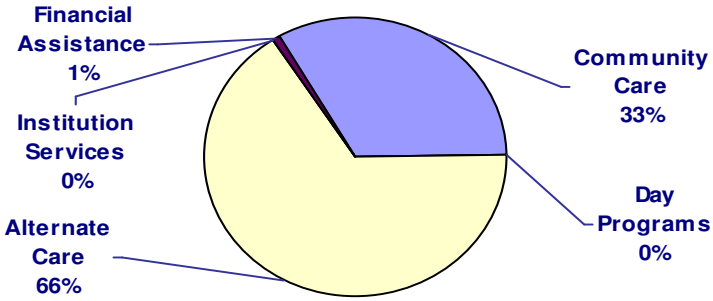


2008 Costs by Service Type

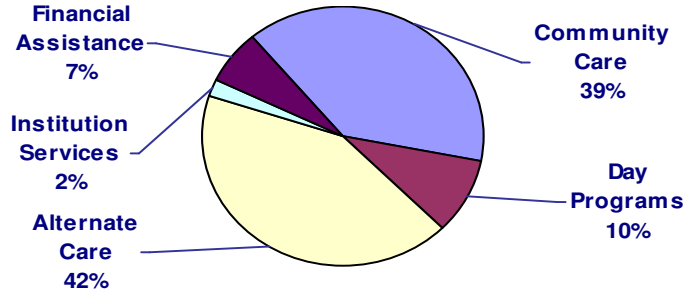
Total Expenditures	
Community Care	13,530,005
Day Programs	2,680,792
Alternate Care	17,076,767
Institution Services	620,437
Financial Assistance	1,959,864
TOTAL	35,867,865



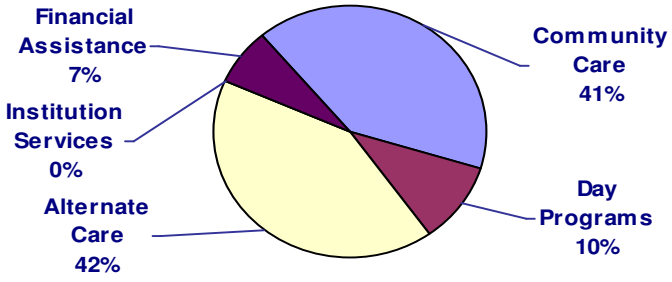
Collections & Donations	
Community Care	2,585,129
Day Programs	0
Alternate Care	5,174,199
Institution Services	0
Financial Assistance	69,348
TOTAL	7,828,676



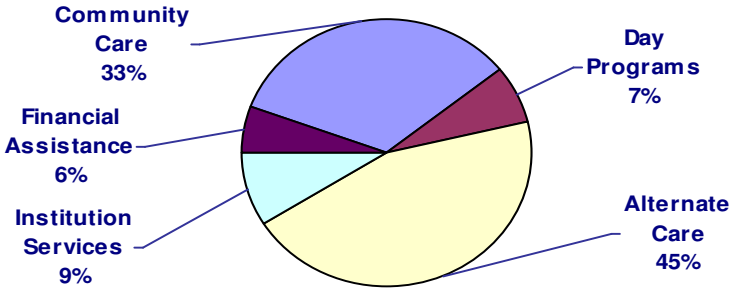
Net Costs	
Community Care	10,944,876
Day Programs	2,680,792
Alternate Care	11,902,568
Institution Services	620,437
Financial Assistance	1,890,516
TOTAL	28,039,189



State & Federal Funding	
Community Care	8,586,739
Day Programs	2,164,675
Alternate Care	8,750,625
Institution Services	0
Financial Assistance	1,492,400
TOTAL	20,994,439



Net County Cost	
Community Care	2,358,137
Day Programs	516,117
Alternate Care	3,151,943
Institution Services	620,437
Financial Assistance	398,116
TOTAL	7,044,750



HEATH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

~ The proper use and disclosure of protected healthcare information, while maintaining confidentiality, integrity and availability in the hybrid county workplace, is the goal of county-wide HIPAA implementation.~

HIPAA is the complex set of federal standards with a direct impact on the treatment, payment, and healthcare operations (TPO) of the Jefferson County Health, Human Services, Human Resources (employee health care information) and Management Information System (MIS) Departments; Countryside Home and the Jefferson County Jail. Human Services employee Charlotte Silvers was designated by County Board Resolution No. 2004-108 to the combined role of HIPAA Privacy and Security Officer in 2005 with the assistance of Deputies in each of the covered entity departments as designated in County Board Resolution No. 2003-05. See also the previously distributed 2005, 2006 and 2007 Human Services Annual Reports for past HIPAA reviews.

A review of HIPAA Officer activities for 2008 includes:

1. Investigated HIPAA alleged patient complaints and county staff/business associate breaches; evaluated potential high-risk situations to prevent a complaint/breach; and served as a resource to staff in both HIPAA and non-HIPAA county departments with advice on HIPAA requirements and handling of protected health care information. For example, met with the Human Services Department, Aging and Disability Resources Center (ADRC, established 2008), Division Manager and Coordinator, on HIPAA, WI State Statutes including 46.23 (Human Services) and documentation requirements.

2. Continued training of health care work force staff, volunteers and students, documented by signature on "Confidentiality Awareness Statements" covering the "need to know" and "minimum necessary" principles for maintaining the confidentiality of protected health care information. Had a meeting with the new Human Services Department MIS contact person for an overview of HIPAA requirements and the procedure for reporting complaints/breaches. Had the opportunity to assess an on-line, HIPAA employee training module for use in county facilities. Continued participation in the Fall HIPAA Collaborative of Wisconsin conference, attending with a Human Services staff accountant involved in the billing of health care services, for sessions on the mandatory changes to the HIPAA healthcare transactions and code sets, and for a general update on the HIPAA COW organization and resources.

3. Held meetings with MIS staff updating the Personnel Ordinance "Computer Use, Internet Access and Telephone Use Policy" to include new technology developed since it was first issued in 2002; continued discussion of policies and procedures to implement regulations of the HIPAA Security Rule; attended webinars on "How to Conduct Your Own HIPAA Audit" and e-Discovery basics; and reviewed proposals and contracts for electronic health record systems at Countryside Home. Began assessment of the employee "Notice of Privacy Practices" as the employee health plan changeover to the state plan took place January 1, 2009. While an additional 18 months under the current notice is available, and each health plan has separate notices for medical care, the other county-sponsored health plan benefits may necessitate a new notice.

4. Reviewed three guidance documents issued by the federal government at the end of 2008. "The Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to Student Health Records" came out in November, 2008. It impacts the exchange of information between schools and county health care providers (trainings are planned in 2009). On November 17, 2008 the federal Department of Labor's "Final Rule" on the Family and Medical

Leave Act (FMLA) was published, which "recognizes the advent of HIPAA and the application of the HIPAA Privacy Rule to communication between employers and employees' health care providers", including a requirement that an employee's direct supervisor may not contact a health care provider but instead must be done by another employee in one of the named categories. In December, 2008 the Office of Civil Rights issued a new HIPAA Privacy Rule guidance as part of a "Privacy and Security Toolkit". This guidance discusses how the Privacy Rule can facilitate the electronic exchange of health care information.

5. Participated with other HIPAA Officers in the critique of the two Notices of Proposed Rule Making (NPRM) issued in 2008. The HIPAA Healthcare Transaction Version 5010 and the International Classification of Diseases, 10th Edition, and Clinical Modification (ICD-10-CM) implementation dates were set. Version 5010 and ICD-10-CM are designed to be used and implemented together, with the deadline of October 1, 2013 for the majority of health care plans and providers. This is the first major change in diagnosis coding since 1979. It includes the expansion of diagnosis codes from a maximum of five digits to a maximum of eight. It should be noted that one phase of this transition will not affect county billing systems, since the Procedure Coding System ICD-10-PCS is for hospital use only. The final rules had a deadline for congressional review of March 15, 2009 (deadline passed, implementation timetable stands as published in 2008).

6. In Fall of 2008 began compiling information on the Federal Trade Commission (FTC) "Red Flags" requirements as information was received that health care accounts had to be included. Officially called the "Fair and Accurate Credit Transactions Act of 2003" (FACTA), it amends the Fair Credit Reporting Act (FCRA). It has a list of twenty-six "Illustrative Examples (alerts or signals)" that may warn of a potential problem requiring action. The rule went into affect January 1, 2008 with compliance originally slated for November 1, 2008 but it was delayed six months until May 1, 2009 because of widespread confusion over what accounts are covered. To be compliant, businesses must adopt a plan to detect, prevent and mitigate identity theft when using credit reports and consumer financial accounts. A subset of identity theft referred to as "medical identity theft" is tied into the HIPAA requirement to protect health care data. Information already available such as the HIPAA Compliance Manual "Medical Identity Theft Response Checklist for Consumers" and the Jefferson County Sheriff's Office "Identity Theft Packet" can be incorporated into this policy. Expect to see more as efforts continue to clarify "what-information-kept-where" is covered.

As anticipated in the 2007 Annual HIPAA Report, the call for increased Privacy and Security Rule enforcement because of publicized breaches has resulted in a change in the federal government's strategy. This strategy is outlined in the American Recovery and Reinvestment Act (ARRA) signed February 17, 2009 by President Barack Obama, which includes increased emphasis on fines; ability to pursue civil penalties when criminal penalties not pursued; issuance of guidance and rules; mandatory annual reports of enforcement efforts; and conducting of privacy audits. While the enforcement rule changes go into effect immediately, other provisions will track a timetable projected into the year 2014. Among the first to be issued (April 17, 2009) will be a Security Rule guidance on "Technologies and Methodologies" for "securing" electronic health care data. Other areas for increased attention are Business Associate Agreeement requirements including vendors offering Personal Health Records (PHR), clarification of HIPAA terms and definitions, Electronic Health Record accounting of disclosures, and establishment of federal regional privacy education efforts. The challenge for 2009 will be to stay on top of the following trends: the unfolding timetable for ARRA changes; prevention of identity theft policies and procedures; preparation of the electronic billing systems in covered entity departments for the transition to Version 5010 and ICD-10-CM; updating of covered entity status for county departments as the fiscal impact of budget shortages are addressed; renew policies, procedures and training methods for HIPAA with increased regulation complexity; and the continued progress towards nationwide implementation of electronic healthcare records (by the year 2014).

The List of 2009 HIPAA Goals and Objectives will form the outline for the next annual report.

HUMAN SERVICES STAFF

Director ~ *Thomas Schleitwiler*

Deputy Director ~ *Daniel Gebauer*

Medical Director ~ *Mel Haggart, M.D.*

Administrative Services Division Manager, *Dan Gebauer*

- ~ Fiscal, *Dan Gebauer*
- ~ Maintenance, *Terry Gard*
- ~ Office Manager & Support Staff, *Donna Hollinger*

Aging and Disability Resource Center/Aging Division Manager, *Sue Torum*

- ~ Aging, *Sue Torum*
- ~ Aging & Disability Resource Center, *Sharon Olson*

Behavioral Health Division Manager, *Kathi Cauley*

- ~ Community Support Program, *Marj Thorman*
- ~ Comprehensive Community Services, *Kim Propp*
- ~ Mental Illness/AODA, *Karen Marino*
- ~ Lueder Haus, *Terri Jurczyk*

Economic Support Division Manager, *Jill Johnson*

- ~ Economic Support Programs, *Jill Johnson*
- ~ W-2 Programs, *Sandy Torgerson*

Family Resources Division Manager*, Terri Smyth-Magnus*

- ~ Child Welfare*, Autumn Pohlman*
- ~ Early Intervention Program, Busy Bees Preschool, *Diane Bazylewicz*
- ~ Youth Delinquency, *Beverly Marten*
- ~ Wraparound – *Barb Gang*
- ~ Developmental Disabilities, *Patti O'Brien*

TEAMS AND STAFF

AGING
Sue Torum, *Supervisor*
Doug Carson
Jackie Cloute
Betty Droster
Beth Eilenfeldt
Sharon Endl
Donna Gnabasik
Denise Grossman
Patti Hills
Mary Kraimer
Martha Partker
Sandy Shannon
Nancy Toshner
Lynn Walton

AGING AND DISABILITY RESOURCE CENTER
Sharon Olson, *Supervisor*
Diane Curry
Sandra Free
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